

Case Study Summaries of Six Centralized Intake Systems that Promote Enrollment into Home Visiting

September 2026

OPRE Report #2026-035

Case Study Summaries of Six Centralized Intake Systems that Promote Enrollment into Home Visiting

OPRE Report #2026-035
September 2026

AUTHORS:
Mathematica: Jill Spielfogel, Rebecca Kleinman, Abby Capella, Milena Raketic, Yuri Feliciano, Jessica F. Harding, and Charlotte Cabili
Brazelton Touchpoints Center: Catherine Ayoub, Christina Mondi-Rago, John Hornstein, and Angelica Guerrero
Social Grove: Ashton Chapman

Submitted to:

Laura Nerenberg and Jesse Coe
Office of Planning, Research, and Evaluation
Administration for Children and Families
U.S. Department of Health and Human Services

Submitted by:

Rebecca Kleinman, Project Director
Mathematica
1100 First Street, NE, 12th Floor
Washington, DC 20002-4221

Contract number: 47QRAA18D00BQ/75ACF121F80023

This report is in the public domain. Permission to reproduce is not necessary.

Suggested citation: Spielfogel, Jill, Rebecca Kleinman, Abby Capella, Milena Raketic, Yuri Feliciano, Jessica F. Harding, Charlotte Cabili, Catherine Ayoub, Christina Mondi-Rago, John Hornstein, Angelica Guerrero, and Ashton Chapman. (2026). *Case Study Summaries of Six Centralized Intake Systems that Promote Enrollment into Home Visiting*, OPRE Report #2026-035, Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Disclaimer: The views expressed in this publication do not necessarily reflect the views or policies of the Office of Planning, Research, and Evaluation, the Administration for Children and Families, or the U.S. Department of Health and Human Services.

This report and other reports sponsored by the Office of Planning, Research, and Evaluation are available at www.acf.hhs.gov/opre.









The Understanding and Expanding the Reach of Home Visiting (HV-REACH) Project

The HV-REACH project developed and disseminated evidence-informed resources and strategies that home visiting programs can use to increase access to and participation in home visiting services among eligible families. Mathematica conducted this project in partnership with the Brazelton Touchpoints Center and Social Grove on behalf of the Office of Planning, Research, and Evaluation (OPRE) in the Administration for Children and Families (ACF), in collaboration with the Maternal and Child Health Bureau (MCHB) in the Health Resources and Services Administration (HRSA).

Acknowledgments

We extend our sincere appreciation to our federal project officers and partners in ACF and HRSA for their leadership and guidance: Laura Nerenberg, Jesse Coe, and Katie Pahigiannis of OPRE; Maggie Kane, Soohyun Kim, and Ayanna Williams of HRSA; Kristyn Wong VanDahm, formerly of ACF; with a special thanks to Kelly Jedd McKenzie of ACF for her direction and leadership as project officer until the project neared its end. We are also grateful to our colleagues for their contributions to the early stage of the study, including with tasks such as developing plans for analysis, site selection, recruitment, and interviewing—Julius Anastasio, Patricia Del Grosso, Ana Maria Melendez Guevara, Brandon Hollie, Nuzhat Islam, Joe O'Brien, Jaimie Orland, and Lauren B. Rosenberg. In addition, Nikki Aikens and Elizabeth Cavadel provided thoughtful quality assurance. We also appreciate the efforts of other colleagues at Mathematica: Effie Metropoulos, Maura Butler, Carol Soble, and Donovan Griffin for editorial support; Sheryl Friedlander and Allison Pinckney who managed production; and Yvonne Marki and Jon Owolabi, who contributed graphic design. In addition, the HV-REACH Centralized Intake Committee provided input on site selection, interview guides, recruitment processes, and the findings; thank you to Stephanie Beverly, Julie Leis, Katy Leopard, Maria Maestas, Melissa Miller, Allison Parish, Laura Taylor, Allison West, and Susan Zaid. Finally, we extend our deepest thanks to the staff at the centralized intake systems and staff and families with the home visiting programs that participated in the study for generously sharing their time and insights.

This page has been left blank for double-sided printing.

Contents

I. Introduction 1

II. Delaware's *Help Me Grow at 211* 5

III. Florida's *Connect* 13

IV. Indiana's *My Healthy Baby* 25

V. Missouri's *Coordinated Referral and Intake System* 35

VI. New Jersey's *Connecting NJ* 45

VII. Tehama County's *Pregnancy to Preschool Partnership* 57

VIII. Conclusion 67

Exhibits

I.1. Map of the six centralized intake systems that participated in the case studies 2

I.2. Features of six centralized intake systems in the case studies 3

II.1. *HMG at 211*'s process for referring families to home visiting programs 5

III.1. *Connect*'s process for referring families to home visiting programs 13

III.2. Map of Healthy Start Coalitions that participated in the case study 15

III.3. Number of families processed annually through *Connect*, from outreach to referral 19

IV.1. *MHB*'s process for referring pregnant women to home visiting programs 25

IV.2. Indiana *MHB* outreach to women and enrollment in home visiting (July 2023–June 2024) 29

V.1. *CRIS*'s process for referring families to home visiting programs 35

V.2. Map of Missouri's collective impact regions that participated in the case study 37

VI.1. *Connecting NJ*'s process for referring families to home visiting programs 45

VI.2. Map of *Connecting NJ* lead agencies that participated in the case study 46

VII.1. *P2P* partner organizations and their services 57

VII.2. *P2P*'s process for referring families to home visiting programs 58

This page has been left blank for double-sided printing.

I. Introduction

Purpose

The Understanding and Expanding the Reach of Home Visiting (HV-REACH) project conducted qualitative case studies of six centralized intake systems that match families with home visiting programs. Centralized intake systems, also referred to as coordinated intake and referral systems, are one-stop entry points where families can learn about services that ideally meet their needs and preferences, and then be screened for and referred to the services.

Additional resources from HV-REACH

Search the Office of Planning, Research, and Evaluation website for more resources, including the companion cross-site report, "Using Centralized Intake Systems to Support Home Visiting Outreach and Referral: Cross-Site Findings from Six Systems."

In communities that have them, centralized intake systems are typically just *one* source of referrals to home visiting programs. Apart from centralized intake systems, home visiting programs may also receive referrals from another system or provider (such as one in health care, child welfare, or social services). Centralized intake systems may improve efficiency and reduce duplication for both home visiting programs and the systems or other organizations that refer families to the programs.[i, ii] They accomplish this by centralizing outreach, screening, and referral processes across multiple home visiting programs. By strengthening the referral pathway to home visiting, centralized intake systems may also help administrators of state Maternal, Infant, and Early Childhood Home Visiting (MIECHV) programs[1] and local home visiting programs reach more families that are eligible for and interested in their services, especially as some states expand their MIECHV Program.[iii]

The study's goals were to:

1. Understand the features, strengths, and challenges of the six centralized intake systems
2. Explore how staff and families think the centralized intake systems promote and expand family enrollment in home visiting programs
3. Understand families' experiences with centralized intake systems

This report contains detailed summaries of each of the six participating centralized intake systems as of 2025. Each summary describes the system's (1) development and goals; (2) structure and operations; (3) process for conducting outreach, screening, matching, and referrals to home visiting programs; (4) approach to documentation and data sharing; and (5) successes, challenges, and opportunities for improvement.

[1] The MIECHV Program is a federal initiative dedicated to funding voluntary, evidence-based home visiting services nationwide for expectant parents and families with young children. The Program aims to improve the health of mothers and children, strengthen families, support positive early childhood development, and connect families to other resources in their community. (Health Resources and Services Administration. "Maternal, Infant, and Early Childhood Home Visiting Program: Report to Congress 2025." Rockville, MD: Health Resources and Services Administration, 2025. https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/home-visiting/miechv-fy-2025-report-congress.pdf.)

How to use the case study summaries

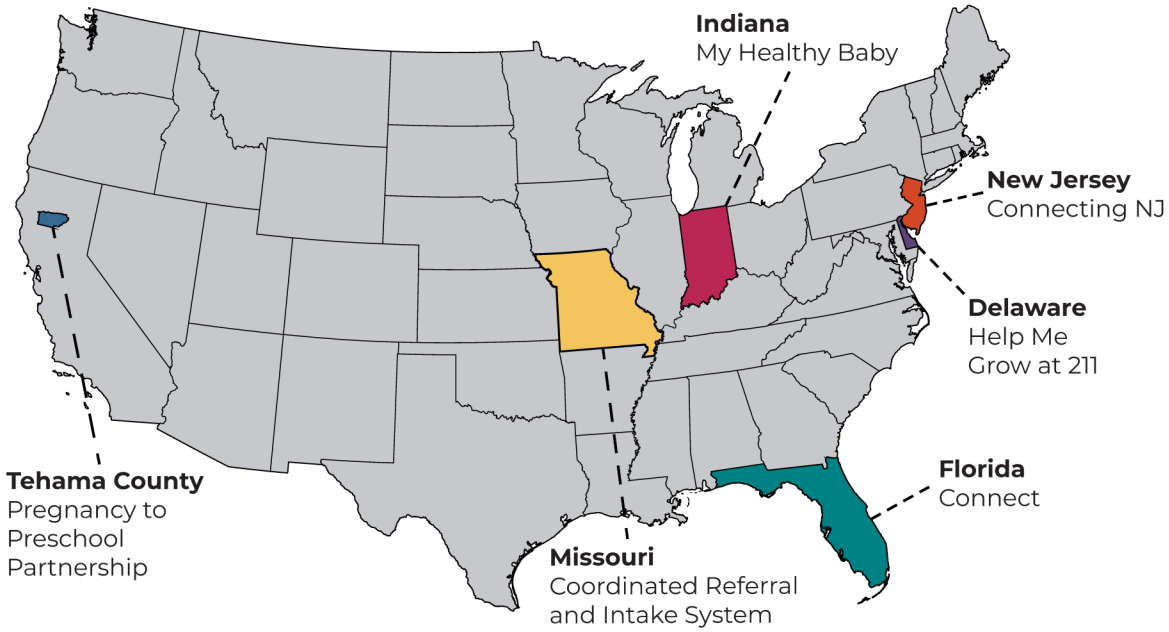
Administrators from existing centralized intake systems and state or local home visiting leaders who are considering implementing them can use these summaries to learn how six systems started and how they operate. The case study summaries may be read independently, so readers can explore the examples that best match their needs without reviewing all six. Because the six centralized intake systems vary in features—such as their size, scope, partnerships, and data system capabilities—state and local administrators might wish to focus on the case study summaries that align most closely with their own system or their plans for one.

Methods

The cross-site report, "Using Centralized Intake Systems to Support Home Visiting Outreach and Referral: Cross-Site Findings from Six Systems," has detailed information about the study methods. This report can be found on the Office of Planning, Research, and Evaluation website using the website's search function. Here, we briefly summarize the methods used to select sites and collect and analyze data.

Site selection. The project team began the site selection process by reviewing information about 30 potential sites that were either recommended to us or found by searching the web. We applied eligibility criteria, such as whether the system had been in operation for at least six months and made referrals to home visiting programs within the past two months. We used a range of considerations to prioritize sites for recruitment, including scope, U.S. geographic region, and services offered. Exhibit I.1 shows the six centralized intake systems that participated in the case studies.

Exhibit I.1. Map of the six centralized intake systems that participated in the case studies



Data collection and analysis. Data collection included document reviews and pre-visit conversations followed by semi-structured virtual interviews with centralized intake staff, home visiting program staff, and families that had recently enrolled in home visiting after a referral from the centralized intake system. Interviews were conducted between March and October 2025 and ranged from less than 60 minutes to 90 minutes. Participants were offered a $40 or $60 gift card depending on the length of the interview. We conducted interviews in English or Spanish with one parent from each participating family. All parents interviewed were mothers. The project team used qualitative coding software (NVivo) to code interview notes and extract key findings, then compiled findings into a case summary. The primary contact from each centralized intake system reviewed the summary for accuracy.

Overview of the centralized intake systems

Exhibit I.2 may help readers decide which case studies are relevant to their context. It highlights some differentiating features of the six systems to help readers identify the case studies that best align with their programs. For example, a small county with limited resources could consider reading Tehama County's approach. Alternatively, a regional approach to centralized intake is described in the Florida, Missouri, and New Jersey summaries.

Exhibit I.2. Features of six centralized intake systems in the case studies

Centralized intake system	Governing agency or agencies	Implementing agency or agencies	Funding sources	Most common referral source or sources	Approximate annual number of referrals processed by system[a]
Statewide scope with a state-level implementing agency					
Delaware *Help Me Grow at 211*	**State agency:** Division of Public Health within the Department of Health	Contracted social services provider (The United Way)	MIECHV Program; Early Childhood Comprehensive Systems Program;[b] other state sources	Community health providers; Delaware at 211 Helpline	Contact made with 1,034 families
Indiana *My Healthy Baby*	**State agencies:** Department of Health, Family Social Services Administration, and State Department of Child Services	Department of Health (Moms Helpline)	Medicaid; other state sources	Medicaid agency	Attempted to contact 56,641 families; screened 16,724 families
Statewide scope with regional implementing agencies					
Florida *Connect*	**State and quasi-governmental organizations:** Department of Health with Healthy Start MomCare Network; the Florida Association of Healthy Start Coalitions	32 Healthy Start coalitions (social service providers and one local health department)	Medicaid; other state sources	State's universal system for prenatal and infant risk screening	289,983 referrals sent to centralized intake system; contact made with 161,339 families

Centralized intake system	Governing agency or agencies	Implementing agency or agencies	Funding sources	Most common referral source or sources	Approximate annual number of referrals processed by system[a]
Missouri *Coordinated Referral and Intake System*	**Quasi-governmental organization:** Children's Trust Fund	Five contracted providers (hospitals and community-based organizations)	State sources	Pediatric providers; Medicaid agencies; child welfare agency	2,580 families matched to home visiting
New Jersey *Connecting NJ*	**State agencies:** Department of Health and Department of Children and Families	Seven contracted providers (social service or health organizations)	MIECHV Program; Early Childhood Comprehensive Systems Program;[b] state sources	State's universal screenings; community partners	Data not available
Countywide scope with collaborative network for implementation					
Tehama County, California *Pregnancy to Preschool Partnership*	**Quasi-governmental organization:** First 5 Tehama	First 5 Tehama and seven early childhood providers in the partnership network	State sources	Referral network of early childhood partners	223 referrals sent between partners in the partnership network

Note: A quasi-governmental entity is established by a government agency to manage services while operating with a degree of independence similar to that of a nonprofit or private organization.

[a] When asked about the number of referrals their centralized intake system processes, administrators provided different measures over different time periods. The 12-month periods across the systems are as follows: Missouri: January 1, 2025, to December 31, 2025; Florida and Tehama County: July 1, 2024, to June 30, 2025; Delaware: January 1, 2024, to December 31, 2024; Indiana: July 1, 2023, to June 30, 2024.

[b] The Early Childhood Comprehensive Systems Program is a federally funded initiative to build comprehensive statewide systems of care for young children and their families. The funding helps states build connected, family-centered systems that improve access to high-quality care by identifying needs early and linking children and caregivers to services like health care, mental health support, parenting resources, and basic needs such as food and housing.[iv]

II. Delaware's *Help Me Grow at 211*

This summary describes Delaware's centralized intake system, called *Help Me Grow (HMG) at 211*.[2] Box II.1 shows key features of the system and we summarize *HMG at 211*'s process for referring families to home visiting in Exhibit II.1.

Box II.1. Key features of Delaware's *HMG at 211*

Launch date: 2012

Geographic scope: Statewide

Intended population: Families with children ages prenatal through age 8

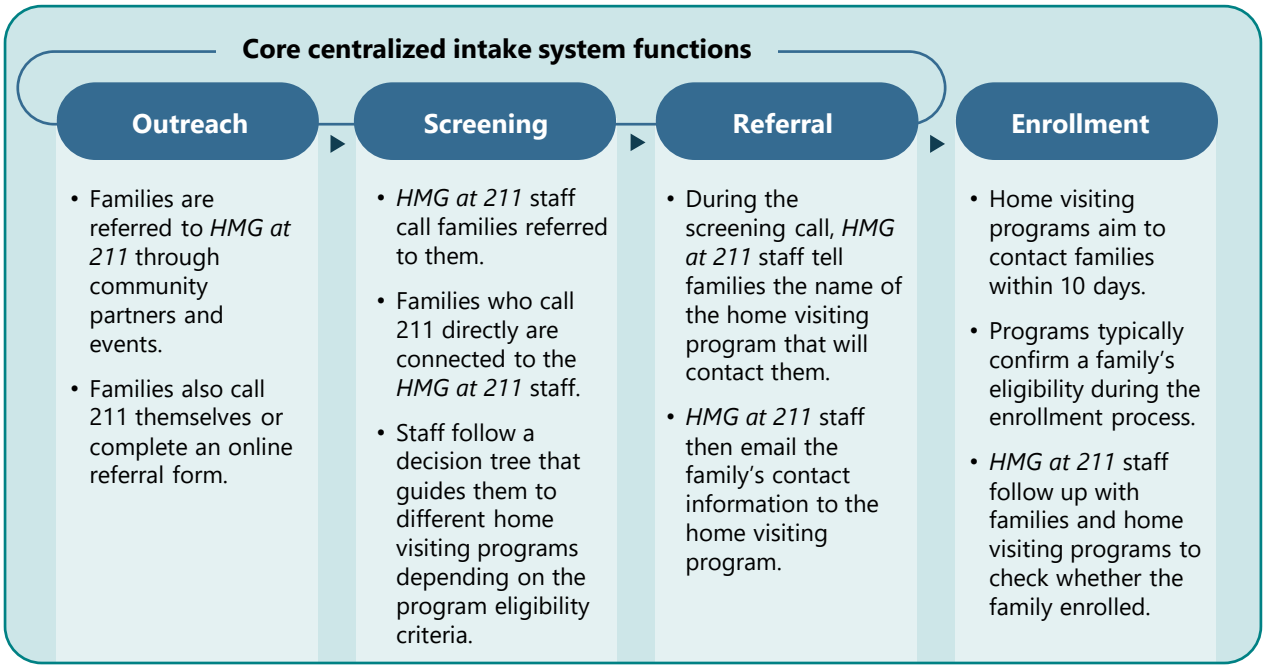
Number of employees: Four full-time employees

Home visiting models it refers to: Early Head Start Home-based Option, Healthy Families America/Smart Start, Nurse-Family Partnership, and Parents as Teachers

Additional services offered by *HMG at 211*: Developmental screenings for children and referrals to food assistance, utility support, medical care, behavioral health care, emergency shelter, and legal assistance

Funding sources: Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program and Delaware Birth to Three Early Intervention Program (Part C)

Exhibit II.1. *HMG at 211*'s process for referring families to home visiting programs



[2] We spoke with 14 participants about *HMG at 211:* four centralized intake administrators and staff, three home visiting staff from two programs that use the Parents as Teachers model, and seven families from these home visiting programs.

Centralized Intake System Development and Goals

Delaware's *HMG at 211* was developed to achieve three main goals:

- **Connect families with young children to developmental resources and supports via a centralized access point.** Delaware's *HMG at 211* was designed to streamline access to community resources like home visiting and other services.[v]
- **Balance enrollment in home visiting programs.** Some home visiting programs were at capacity whereas others were under-enrolled. Thus, another goal was to share referrals evenly and balance enrollment across programs.
- **Encourage more developmental screenings.** In 2007, Delaware ranked among the lowest in the country for the number of young children who received developmental screenings.[vi] Implementing *HMG at 211* was one strategy among efforts to improve the state's ranking on the number of families receiving a developmental screening.

Staff at the Delaware Maternal and Child Health Bureau partnered with United Way, which operates the statewide 211 helpline.[vii] Delaware 211 connects people to essential resources, drawing from a comprehensive database of assistance programs and support services. In 2011, the state's Maternal and Child Health Bureau and United Way embedded *HMG at 211* in the statewide system to help families with young children learn about available resources.

Home visiting programs and other organizations collaborated to establish *HMG at 211*. The Maternal and Child Health Bureau and United Way partnered with home visiting programs, the Delaware Department of Education, other state agencies, and community organizations. As part of this collaboration, the home visiting programs contributed to a decision tree to guide *HMG at 211* staff to match families with the best program for them based on their eligibility. *HMG at 211* and home visiting staff noted that the home visiting programs did not initially trust that the system would lead to more referrals, but they saw referrals to their programs increase over time.

***HMG at 211* has two main sources of funding:** (1) the Delaware Division of Public Health's MIECHV Program and (2) the Delaware Birth to Three Early Intervention Program (which administers Part C of the Individuals with Disabilities Education Act).[viii] In 2024, the two sources gave *HMG at 211* a total of $250,000, which was less than *HMG at 211* received in 2023 ($400,000) from these sources.

Box II.2. *HMG at 211* core team

- The leader of the Early Childhood Comprehensive Systems Program in the Delaware Maternal and Child Health Bureau at the Division of Public Health
- One Delaware 211 director who is also the *HMG at 211* manager
- Two individuals from the Delaware chapter of the American Academy of Pediatrics: the director and a physician champion
- An external data evaluator
- A consultant responsible for family and community engagement

Structure and Operations

Administration and staffing

A core team of staff oversees the system and three United Way employees operate *HMG at 211* (Box II.2). The core team discusses strategic planning and guides high-level decision making for *HMG at 211*. At United Way, staff respond to incoming calls, call referrals, conduct developmental screenings, and coordinate referrals with home visiting programs. Staff

in leadership roles provide quality assurance for calls and oversee staff training. Staff that operate *HMG at 211* have experience with early education, early child development, and family engagement. All staff receive training in developmental screenings, the evidence-based home visiting models available in Delaware, and how to use the phone and operating systems that run *HMG at 211*.

Oversight

The Help Me Grow Advisory Committee is the system's primary steering group.[ix] Formed in 2012 by the Division of Public Health's Maternal and Child Health Bureau, the committee develops goals for strengthening the entire Help Me Grow system in Delaware.[3] Committee members represent Delaware's early childhood, health, education, and social services communities. They meet bimonthly to share data, provide feedback on programming, and discuss developmental screening data.

Delaware's Home Visiting Community Advisory Board focuses on the quality and availability of home visiting services throughout the state.[ix] Members of this board, which meets quarterly, include United Way staff from *HMG at 211*; the Delaware Department of Services for Children, Youth and Their Families; the Delaware Department of Education; Medicaid managed care organizations; Prevent Child Abuse Delaware; and home visiting programs.

Outreach

Families get connected to *HMG at 211* in four main ways:

- **Community partners refer families to *HMG at 211*.** Community health workers are a common source of referrals (Box II.3). *HMG at 211* is also in the second year of a partnership with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), which refers families to *HMG at 211* and in turn also receives referrals from the centralized intake system.
- **Families contact 211 in search of resources and are transferred to *HMG at 211* for parenting or pregnancy resources.** If they call for other resources, such as assistance with basic needs, child care, and prenatal care, 211 staff inquire whether families are expecting a baby and/or parenting. If so, they are automatically transferred to *HMG at 211*. In addition to responding to the initial reason for the call, *HMG at 211* staff assess eligibility and ask families if they are interested in home visiting. Families can also complete a referral form online to receive a call from *HMG at 211*.[ix]
- ***HMG at 211* staff conduct community outreach.** Each staff member attends at least eight events a year—for example, health fairs and events with supplies for children. *HMG at 211* staff attend many of the same community events as home visiting staff. Delaware Maternal and Child Health Bureau staff provide materials to home visiting programs and encourage them to promote *HMG at 211* when they attend different events.

Box II.3. Community health workers

Community health workers are a key part of a Delaware Division of Public Health initiative to connect women to needed services. They work in doctors' offices, Medicaid managed care organizations, child care centers, and prenatal care clinics. They provide case management–like services such as counseling, social support, and referral linkages.

[3] Delaware Help Me Grow is distinct from *HMG at 211*. Delaware Help Me Grow is part of a coalition of more than 30 states associated with the Help Me Grow National Center, a national system to comprehensively support families with children ages birth to 5. It encompasses a centralized access point; outreach to families, communities, and child healthcare providers; and data collection and analysis. (Help Me Grow National Center, 2026. www.helpmegrow.org)

- **Word of mouth between families** is another common referral pathway, according to *HMG at 211* staff.

When explaining home visiting to families, staff at *HMG at 211* refer to home visiting as a "parent support program." They tell families they will be assigned a parent educator who will meet them where they feel comfortable. They note that the program is a free resource to help with pregnancy, breastfeeding, and other family supports. Box II.4 shares families' perspectives on various aspects of outreach.

Box II.4. Family perspectives on home visiting outreach

- Five of the seven families interviewed reported connecting directly to home visiting programs or *HMG at 211* through community health workers in the hospital when their child was born or during prenatal healthcare visits.
- One family learned about home visiting from a family friend and self-referred, and one family learned about home visiting through their insurance company and contacted *HMG at 211* to learn more.
- Most families thought the process of outreach worked well, but some had recommendations such as having a bigger online presence and more flyers in doctors' and social services' offices.

Screening and Referrals

Collecting information on families and matching them to a home visiting program

***HMG at 211* collects information on families to determine whether they are likely eligible for a home visiting program.** The screening calls take about five minutes and include questions about location, contact information, whether the family receives public benefits, employment, children's age (or due date), and family stressors (such as medical needs, teen pregnancies, or substance-exposed infants). *HMG at 211* staff can also text families if they have trouble reaching them over the phone or if the family prefers texting.

> *Instead of everyone thinking of different places to send people, they all come to us. We get all the information and so we know the appropriate program to send them to.*
>
> — *HMG at 211* staff

***HMG at 211* staff use a decision tree to determine which program to refer the family to.** If a family matches with more than one program, *HMG at 211* workers use their own judgment, considering location and family circumstances to determine the best fit. Most families are matched with a home visiting program immediately. At the end of the call, *HMG at 211* staff tell the family which home visiting program their information will be sent to and, if they have it, the name of the program staff who will call them. Box II.5 shows the status of home visiting–related calls to *HMG at 211* in 2024.

Box II.5. *HMG at 211* contact with families in 2024

- **306** referrals to home visiting programs
- **41** callers seeking information about home visiting
- **65** had already enrolled in home visiting
- **12** were ineligible for home visiting
- **610** callers declined home visiting programs (either the centralized intake staff were unable to contact the family, or the family declined)

Referral to and coordination with home visiting programs

Each home visiting program has a designated *HMG at 211* contact. Staff at *HMG at 211* communicate with Delaware's home visiting programs via email or phone to share referrals and follow-up. One of the two home visiting programs interviewed reported receiving about 60 percent of its families from *HMG at 211*, and the other reported about 90 percent, or 5 to 15 referrals from *HMG at 211* per month.

***HMG at 211* staff follow up with families to find out whether they connected with the home visiting program.** *HMG at 211* staff said that if a family has not heard from the program within eight to 10 business days, staff follow up with the program to learn the status of the referral. Sometimes, the staff also notify the referral source of the status.

Home visiting programs share information about referral outcomes, family enrollment, and program capacity with *HMG at 211*. *HMG at 211* then tracks this information in its iCarol data system.[4] Staff at the two home visiting programs we spoke to said they sometimes refer families to *HMG at 211* to help meet additional needs. Although most home visiting programs in Delaware do not have wait lists, some programs do for non-English speakers, particularly Spanish- and Haitian-Creole–speaking families.

Enrollment in Home Visiting Programs

Home visiting staff contact the families to confirm their interest in home visiting. The directors of the two home visiting programs we spoke with said that after they receive a referral from *HMG at 211*, they assign families to home visitors, who contact families to discuss their program. One home visiting program has a policy to call, text, or email within 48 business hours of receiving a referral. Staff from this program said it may take up to four attempts to contact a family. The other program has a goal of calling within three days and scheduling the first visit soon after. Box II.6 describes what families said about the enrollment process. In some cases, home visiting programs receive direct calls from families interested in enrolling. When families reach out directly, if they are eligible, programs enroll them without involving *HMG at 211*. They may also redirect others to *HMG at 211* or another home visiting program that better matches the family's circumstances.

Box II.6. Families' experiences enrolling in home visiting through *HMG at 211*

- Three families said it took about two weeks to four months between talking to *HMG at 211* and receiving a call from the home visiting programs. Two of these three noted that holidays, weather events, and errors in phone numbers may have had an impact on the timeliness of the connection.
- Families reported receiving simple, accurate information about home visiting from *HMG at 211* staff. After connecting with a home visitor, they received more detailed descriptions of the programs.
- Four families interviewed did not say they talked with anyone at *HMG at 211*, which may be because they did not remember the short conversation.

[4] iCarol is a client management, information and referral software commonly used by human-services organizations and nonprofits. (https://www.icarol.com/)

Home visiting programs obtain additional information from families to determine eligibility. The two interviewed programs reported confirming information received from referral sources (including *HMG at 211)* with the families. After confirming interest and eligibility, the home visitors meet with families to complete the home visiting enrollment forms in person or virtually.

Home visiting programs noted limited differences between families referred by *HMG at 211* and families referred in other ways. For instance, families referred by sources outside of *HMG at 211* may know more about home visiting because they learned about it through a friend or family member. Families referred by the Delaware Department of Services for Children, Youth and Their Families or the Delaware Birth to Three Early Intervention Program have typically been "highly recommended" to participate and may be more likely to enroll. Furthermore, *HMG at 211* staff shared that families that called 211 for a resource unrelated to home visiting were usually the least likely to be interested. One home visiting staff member noted that the program received more prenatal referrals from *HMG at 211* than from other referral sources (likely due to the high referral rates from community health workers, who are located in hospitals).

> *We have a good relationship that we know monthly where they're at with their capacity … it's rare for a program to decline a family.*
>
> — *HMG at 211* staff

Documentation and Data Sharing

The process of sharing data between *HMG at 211* and home visiting programs has worked well. Some home visiting programs are equipped to import *HMG at 211* referral forms, which are sent via email, into their own data system. Home visiting programs thought the information shared by *HMG at 211* referrals was sufficient but noted that some family information may be missing at times (such as due date, number of children, or healthcare provider's name). Staff at *HMG at 211* appreciate the flexibility of the data system.

***HMG at 211* takes precautions to maintain family privacy when sharing data.** Only staff internal to *HMG at 211* can access the iCarol data system that houses resources and family information—this includes United Way staff and state-level administrators. Home visiting programs do not share any additional family information they collect with *HMG at 211,* including whether a family enrolls in home visiting.

***HMG at 211* analyzes and shares aggregate data in monthly reports to home visiting programs** (Box II.7). *HMG at 211* also shares monthly reports with the state Maternal and Child Health Bureau. The reports have data on the number of *HMG at 211* calls, the counties families live in, key issues or concerns of callers, whether families are expecting a baby, whether a family receives public assistance, and the number and type of referrals made.

Box II.7. Home visiting information included in *HMG at 211*'s monthly reports

- Number of referrals to *HMG at 211*
- Number of callers seeking home visiting information
- Number of callers already receiving home visiting services
- Reasons callers declined home visiting referral
- Reasons for ineligibility
- Number of home visiting programs referred to
- Names of home visiting models referred to
- Whether any screenings were completed on the call
- Number of callers who accepted referrals

Reports from an external evaluator inform implementation strategies, funding and grant applications, and legislative reports. Delaware's external evaluator uses data from *HMG at 211* to create reports for the advisory committees and others working at the state level. State administrators use these reports to identify gaps and develop strategies to address them (for example, by planning for additional services).

Successes, Challenges, and Opportunities for Improvement

Successes

Noted successes included the following:

> *It's been wonderful in terms of getting referrals, but also in terms of the resources that they have available to our families. They have this massive database and [the families] are given the information in a very timely way. So, it's a huge benefit to families in our community.*
>
> — Home visiting staff

- **Increase in the number of callers.** From 2020 to 2024, the number of calls to *HMG at 211* increased by 171 percent, from 1,537 to 4,170 calls per year. *HMG at 211* aims to increase contacts every year by 10 percent.
- **A simple, streamlined process that increases referrals to home visiting programs.** Staff from *HMG at 211*, state-level administrators, and home visiting staff said the process of screening and referring families is easy and straightforward. They thought the way *HMG at 211* matches families with home visiting services is efficient and effective and noted that the follow-up *HMG at 211* staff provide after making referrals is especially important for ensuring the home visiting program reaches out to them. Home visiting programs particularly appreciate *HMG at 211* because it helps reduce the burden on home visitors to find families to fill their caseload, which allows them to spend more time supporting families.
- **Positive communication and high level of coordination.** Staff from *HMG at 211*, state-level administrators, and home visiting staff all agreed that the close relationship and collaboration between staff at *HMG at 211* and the home visiting programs has fostered system success. Years of communication and planning helped build support for the system, and low staff turnover at *HMG at 211* further strengthened the relationship.
- **Strong community partnerships.** *HMG at 211*'s investments in community outreach have been another key to improving access to home visiting. Embedding the *HMG at 211* system within Delaware 211 has also helped connect families to more services and supports. Because they share a data system, it is easy for *HMG at 211* staff to share Delaware 211's resources with families and home visiting programs.

Challenges and opportunities for improvement

The challenges reported by *HMG at 211* and home visiting staff mainly involved recruitment:

- **Connecting with families.** Families often do not answer phone calls or respond to text or email messages, making it difficult to connect and provide support. Staff at *HMG at 211* thought this was the most significant barrier to family engagement.
- **Some staff noted that families may hesitate to have strangers in their homes.** In these cases, *HMG at 211* staff let families know they can meet their home visitor in a public place (such as a park or

library). In addition, staff noted a possible reluctance to engage with home visitors because the role sounds similar to the role of child welfare caseworkers for the Delaware Department of Services for Children, Youth and Their Families. One staff person expressed concern that the general public is not aware of home visiting programs.

Other challenges included:

- **Achieving initial buy-in from home visiting programs.** Staff from *HMG at 211*, state-level administrators, and home visiting programs recalled overcoming challenges in building the decision tree the centralized intake system is built on. The home visiting programs did not initially receive many referrals and questioned its value. Over time, ongoing communication improved the relationship between home visiting programs and *HMG at 211* and the referral process grew stronger. Home visiting referrals from *HMG at 211* have increased and *HMG at 211* keeps programs informed of important resources and events in the community.
- **Continuing funding to grow the system.** *HMG at 211* staff want to keep growing the system to answer more calls and connect more families to services, but they need more funding to do so.

HMG at 211 staff shared the following areas for improvement:

- **Expanding outreach.** The Delaware Maternal and Child Health Bureau and *HMG at 211* plan to look for new outreach events to attend to expand their promotion of home visiting enrollment and the centralized intake system. Some staff also suggested strengthening *HMG at 211*'s use of social media platforms. Partnering with organizations such as United Way was also suggested to expand visibility and engagement across the state.
- **Improving coordination with community health workers.** The Delaware Maternal and Child Health Bureau would also like to improve communication between the community health workers and the *HMG at 211* staff to increase their use of *HMG at 211* and better coordinate home visiting referrals throughout the state.

III. Florida's *Connect*

This summary describes Florida's *Connect* system. Key features of the system are in Box III.1.[5] *Connect* operates through 32 regional coalitions, called Healthy Start Coalitions. This case study focuses on two organizations that run Healthy Start Coalitions: Broward Healthy Start Coalition and Well Florida Council (which operates Central and North Central Florida Healthy Start Coalitions). Exhibit III.1 shows *Connect*'s process for referring families to home visiting.

Box III.1. Key features of Florida's *Connect*

Launch date: 2018

Geographic scope: Statewide, regional implementation

Intended population: All pregnant or parenting families with children up to age 3

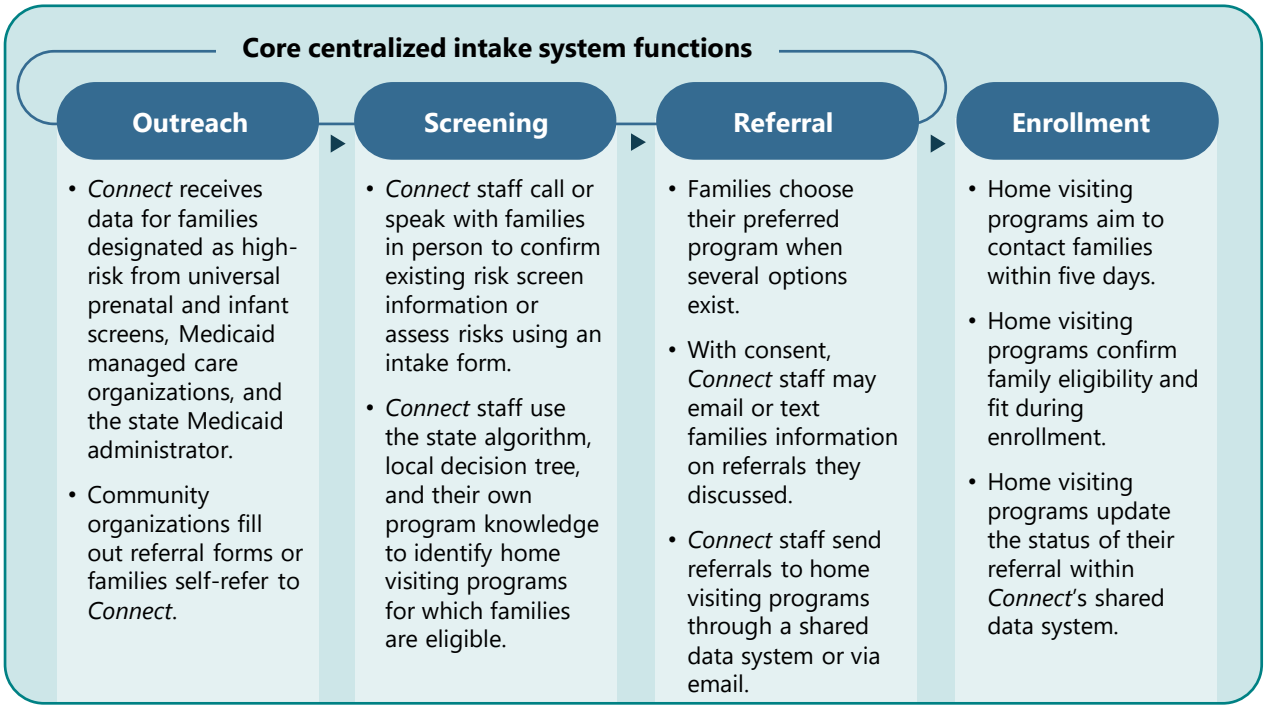
Number of employees: More than 240 staff across the state

Home visiting models it refers to: Early Head Start, Federal Healthy Start, Florida Healthy Start, Healthy Families Florida, Nurse-Family Partnership (NFP), Parents as Teachers (PAT), and several models that do not operate statewide

Additional services offered by *Connect*: Referrals to Medicaid; medical and behavioral health services (such as mental health and drug treatment); the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); housing; child care; and others

Funding sources: Florida Department of Health funding and Medicaid reimbursement

Exhibit III.1. *Connect*'s process for referring families to home visiting programs



[5] We spoke with 21 participants about *Connect*. Box III.7 provides more information about who participated in this case study.

Box III.2 describes Florida's Healthy Start landscape. The Healthy Start Coalitions were designed to support maternal and child health across Florida.

Box III.2. Florida's Healthy Start landscape[x]

- **Florida Healthy Start initiative.** Established in 1991 through statute, the initiative aims to "reduce infant mortality, reduce the number of low-birth weight babies, and improve health and developmental outcomes."[xi] As part of this initiative, Florida statute requires health providers to offer a prenatal risk screen during the first prenatal visit and an infant risk screen after delivery.[xii, xiii]
- **Florida Association of Healthy Start Coalitions (FAHSC)**. A nonprofit founded in 1994, FAHSC provides Healthy Start Coalitions with programmatic support such as education, communication, program development, and advocacy for maternal and child health.
- **Healthy Start Coalitions**. Nonprofit organizations that refer families to services in their communities and subcontract with direct service providers to provide the Healthy Start home visiting program and other services. In accordance with the Florida statute, they cannot provide direct services to families.
- **Healthy Start home visiting program.** The Florida Healthy Start home visiting program is distinct from the federal Healthy Start program and considered the state's "safety net" because it does not limit the number of families it serves.
- **Healthy Start MomCare Network, Inc.** The organization that administers a contract with the Agency for HealthCare Administration for Medicaid-funded services. It functions as a subsidiary of FAHSC and manages *Connect*'s data system, contracting, and administrative functions.

Centralized Intake System Development and Goals

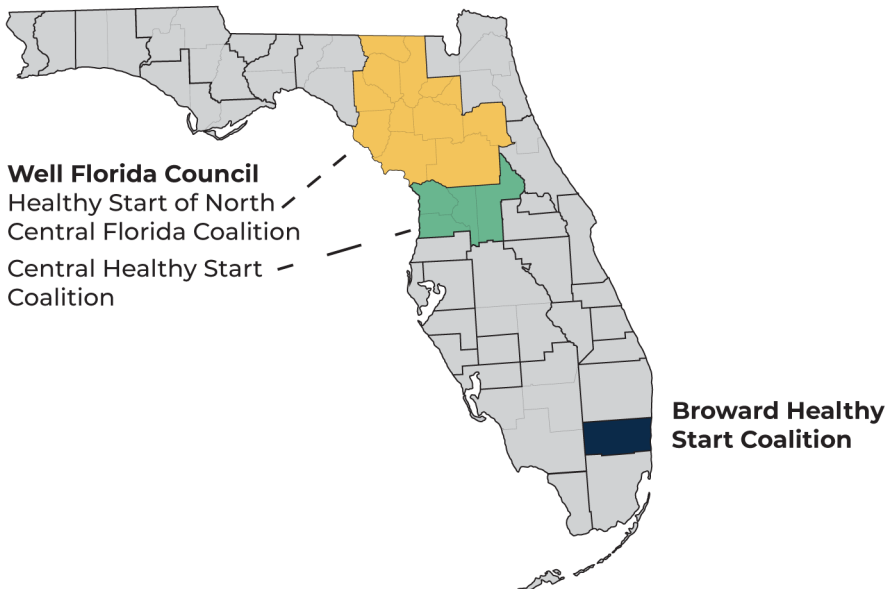
In 2016, Florida conducted a pilot to develop a centralized intake and referral approach that could be scaled through Healthy Start Coalitions across the state. Using funding from the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, the pilot included eight coalitions in Florida.[xiv] Information for families with high needs according to Florida's universal prenatal and infant risk screening was provided to the centralized intake and referral system, which then referred families to evidence-based home visiting and other services. As part of this work, they receive the results of statewide universal prenatal and infant risk screens. Their existing relationships with home visiting programs across the state served as the infrastructure for a centralized intake system.

After successful implementation of the pilot, *Connect* was established statewide in 2018 to achieve three main goals:

- **Offer families a choice of home visiting programs.** Family choice is a determining factor when referring families to home visiting programs. One *Connect* staff member thought that involving families in this decision could encourage them to enroll in home visiting.
- **Reduce and prevent the duplication of services.** Before *Connect* was implemented, different home visiting programs often conducted outreach to or served the same family without realizing it. Home visiting programs, coalitions, and legislators were concerned about the cost of duplicating services. *Connect* helped address this concern by working with home visiting programs to create a centralized intake and referral data system to track enrollment.
- **Increase access to screens and referrals for different home visiting programs.** By Florida statute, completed screens are sent to Healthy Start Coalitions, if parents consent. Before *Connect*, Healthy Start home visiting programs received most of the referrals from the screens because of their relationship

with the coalitions. *Connect* was established in part to link the coalitions with other home visiting programs so the coalitions could evenly distribute referrals resulting from screens and help families understand which program would best meet their needs.

Exhibit III.2. Map of Healthy Start Coalitions that participated in the case study



Note: The bold lines show the 32 Healthy Start Coalitions across Florida counties. The regions that contain organizations that run Healthy Start Coalitions that participated in this case study are shown in color.

Florida's 32 Healthy Start Coalitions implement *Connect* with oversight from the Florida Department of Health, the Agency for Healthcare Administration, and the Healthy Start MomCare Network, Inc. Florida statute created Healthy Start Coalitions to oversee and facilitate connections across the maternal and child health system in their regions, which includes sharing completed prenatal and infant screens. Exhibit III.2 outlines the 32 coalitions. To establish *Connect*, each coalition determined the appropriate staffing for its system, created decision trees with statewide home visiting programs and small home visiting programs that are not available statewide to help match families to programs, expanded home visiting partnerships throughout their regions, and entered into agreements with those programs. In addition, coalitions met frequently with each other and with home visiting programs, developed implementation teams, and applied insights from the pilot and from similar centralized intake system models in other states. The coalitions provided an existing infrastructure that was helpful for implementing centralized intake systems in their regions. The Florida Department of Health, in collaboration with FAHSC, developed the Healthy Start Standards and Guidelines for coalitions to implement Florida's Healthy Start initiative, which included *Connect*. [xv, xvi]

Florida Medicaid and the Florida Department of Health fund *Connect*. The Agency for Healthcare Administration, the state's Medicaid administrator, pays for each successful contact that *Connect* makes with a Medicaid enrollee.[6] Medicaid reimbursement for *Connect* services delivered in one year (from July 1, 2024, through June 30, 2025), was estimated at $10.5 million. Using criteria such as the number of counties served and the number of births in each Healthy Start Coalition's service area, the Department of

[6] *Connect* receives Medicaid reimbursement based on documentation in *Connect's* data system, Well Family System.

Health also provides a fixed lump sum for *Connect* activities with families that do not receive Medicaid, along with funding for outreach and other Healthy Start Coalition activities.

Structure and Operations

Administration and staffing

***Connect*'s day-to-day operations are similar across coalitions, but coalitions have the flexibility to tailor administration to their local contexts and needs.** Coalitions can choose to run *Connect* in-house, contract with an external provider (such as a hospital system) to run it, or a combination of both. Both organizations interviewed operate *Connect* in-house, and one also contracts with local hospitals and health clinics to conduct intake with families in person. The coalitions develop and manage agreements with all the home visiting programs in their regions that *Connect* refers families to. In addition, coalitions train community providers, including hospitals and home visiting programs, on how to use and promote *Connect*.

***Connect* staffing aligns with the region's size, needs, funding levels, and local population.** The size of the *Connect* team at any one coalition varies from four staff in smaller coalitions to more than 30 staff in larger coalitions. Accordingly, staff roles vary across coalitions; staff who work in smaller teams perform multiple roles. The two organizations interviewed had about 20 or more staff, and individuals held one or more roles, including the following:

- **Referral processing specialists or coordinators,** who receive information about families, create cases in Well Family System, and assign cases to intake staff who contact the families. Well Family System is the data system *Connect* uses to track family information and make referrals – it is shared with home visiting programs.
- **Intake specialists or coordinators,** who contact families, conduct intake for *Connect*, and refer families to home visiting and other services.
- **Intake assistants,** who support intake staff, complete follow-up tasks after an initial outreach attempt, and may occasionally help contact families.
- ***Connect* supervisors,** who train staff, monitor referrals, and confirm data are up to date in Well Family System.
- ***Connect* managers,** who maintain partnerships with community providers, conduct outreach for the system, review data in Well Family System, and attend quarterly meetings with their coalition.
- **Quality assurance staff,** who train new staff, promote consistency across *Connect* staff, and confirm data are up to date in Well Family System.

***Connect* staff receive standard training, and coalitions may choose to provide additional training.** In 2024, FAHSC created a standardized onboarding training and manual for all *Connect* staff, supplementing materials that coalitions developed for their own local contexts. The training includes information about applying a standard *Connect* call script, conducting intake and risk screening, operating the data system, and obtaining consent from families.

Oversight

The Florida Department of Health and Healthy Start MomCare Network, Inc. provide oversight and monitoring for *Connect*. The Department of Health is responsible for developing program rules (the Healthy Start Standards and Guidelines) and monitoring funding. The Healthy Start MomCare Network, Inc. monitors *Connect's* performance as part of ongoing quality assurance.

FAHSC supports *Connect* across coalitions. In addition to reviewing statewide data and sharing best practices with coalitions, FAHSC holds quarterly technical assistance meetings for *Connect* supervisors in all coalitions. At the meetings, supervisors work through challenges (such as building trust in the community) and promote peer learning across coalitions. FAHSC also proposes improvements for *Connect* and Well Family System to the Department of Health and advocates for continued legislative support.

Each coalition holds a quarterly advisory group meeting with its home visiting program partners. During these meetings, coalitions share screening and referral data and discuss *Connect* progress and outcomes, local trends, any changes to *Connect*, and home visiting program capacity. *Connect* teams in both regions emphasized the value of maintaining strong partnerships and clear channels of communication with their home visiting programs. Some coalitions also invite local community providers, such as prenatal providers and hospital staff, to these meetings.

> *"Any system of care, to be successful, has to understand that partnership and collaboration is the number one key."*
>
> — *Connect* administrator

The Florida Home Visiting Alliance discusses *Connect* data and considers opportunities for improving *Connect*. The Alliance comprises representatives from all home visiting models in Florida, researchers, and representatives from FAHSC. Although it focuses on the broader home visiting landscape across the state, the group may discuss improvements to *Connect* such as updating the call scripts that *Connect* workers use during intake calls to ensure they are relevant to each program.

Outreach

***Connect* received 289,983 referrals between 2024 and 2025.[xvii] *Connect* uses four main sources to identify families for outreach:**

- **Universal prenatal and infant risk screens.** *Connect* staff receive most of the information about families through completed family screens. Prenatal screens are completed by doctors or nurses during a mother's first prenatal visit and infant screens are electronically filed after birth as part of creating a birth certificate. Prenatal screens are sent to local health departments via electronic file transfer or by providing the physical form. The health departments upload the screens into Well Family System.[xviii] Depending on the score, families may be considered high-risk and flagged for outreach from *Connect*.[7]
- **Lists of newly pregnant Medicaid enrollees.** Through Well Family System, *Connect* staff receive weekly automated lists of mothers flagged by their Medicaid health plan as newly pregnant. Well Family System automatically identifies potential duplicates so *Connect* staff do not enter them twice. Medicaid

[7] In summer 2025, Florida was updating this process to streamline the delivery of information to *Connect*. Newer electronic screens will be shared regardless of score.

health plans may also refer individuals directly to *Connect* through a portal in Well Family System if they think a family could benefit from services *Connect* can link them to.

- **Lists of newly pregnant women who qualify for Medicaid due to their pregnancy.** The Florida Department of Children and Families (the state child welfare agency that processes Medicaid applications), shares information on women who are eligible for Medicaid coverage solely because of their pregnancy.[xix] The Florida Agency for Health Care Administration receives this file from the Department of Children and Families and electronically transmits it to *Connect* each week.
- **Community and self-referrals.** *Connect* has a statewide referral form and toll-free number that families can use to self-refer.[8] Medical providers and other community providers also refer families to *Connect* using online referral forms or by fax, email, or phone. *Connect* staff manually enter all referrals into Well Family System.

In addition, *Connect* staff conduct outreach in communities, and sometimes families find out about home visiting through other avenues. *Connect* managers regularly engage with the community and conduct presentations to raise awareness of *Connect*. In addition, coalitions have provider and community liaisons who collaborate with health providers and attend community events to promote all services available through the coalition, including *Connect*. Home visiting staff and families also said word of mouth and medical providers are popular sources of information about home visiting and *Connect*. Families that learn about home visiting from a program sometimes enroll directly with that program instead of going through *Connect*.

***Connect* staff attempt to contact families within five days of receiving their information.** Both the interviewed *Connect* teams try to contact families as soon as possible (for example, Broward Healthy Start Coalition implemented a 24-hour response for cases from the Department of Children and Families). Box III.3 summarizes the perspectives of several families we spoke with on the outreach process.

Box III.3. Families' perspectives on home visiting outreach

- All seven families that were interviewed were connected to home visiting through *Connect*.
- Two families had heard about *Connect* or home visiting from friends and family, which made them open to sharing their information with *Connect* and participating in home visiting.
- Two families learned about home visiting in their Healthy Start Lamaze class, which they joined after being referred through *Connect*. The Lamaze instructor was also a Healthy Start home visitor.
- Most families thought the outreach process worked well, but some shared additional ideas for improvement, such as having a greater online presence and sharing more flyers in obstetrician and social services offices.

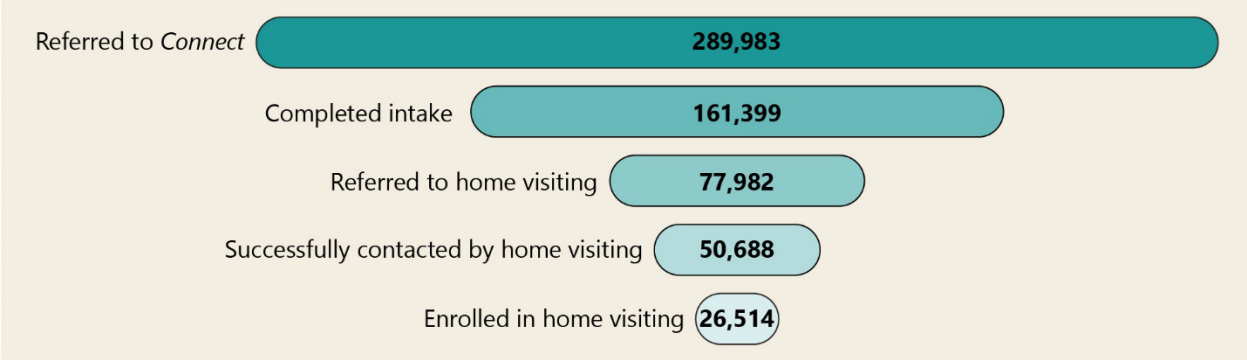
[8] Coalitions also have phone numbers and online referral forms for their local *Connect* programs.

Screening and Referrals

Collecting information on families and matching them to a home visiting program

***Connect* staff confirm information from the risk screen or conduct screening on an intake call with families.** To protect family privacy and client confidentiality, *Connect* staff in both coalitions follow a script that starts by confirming the identity of the individual before completing the intake. Typically, referrals already contain a completed prenatal or infant screen for the family. *Connect* staff review information from the screens they have and update the information on the intake form in Well Family System, if needed, during the call with the family. If they do not have the screen, *Connect* staff assess and document risk factors that are similar to those in the screens during the intake call. Risk screens ask for information about education level, marital status, mental health, financial situation, and the child (such as birth weight and the baby's health at birth). *Connect* staff estimated it takes about five to 10 minutes (and sometimes up to 30, depending on the family) to confirm the family information they receive or screen and refer the family to home visiting.

Exhibit III.3. Number of families processed annually through *Connect*, from outreach to referral



Source: Well Family System data from July 2024 through June 2025.

***Connect* completed intake for about 160,000 families across the state between 2024 and 2025.** Of those who successfully completed intake, about 48 percent were referred to home visiting. Exhibit III.3 summarizes intake and referral data from *Connect* from July 2024 through June 2025. The percentage of families that complete intake and are referred to home visiting varies by coalition.

Well Family System uses an algorithm to find out the statewide home visiting models that families are eligible for based on the screening results. The algorithm matches families to programs they may be eligible for and that have availability. FAHSC worked with Florida's statewide home visiting programs to develop the scoring and model score thresholds.[9] However, *Connect* staff have flexibility in how they use the algorithm. For example, if families do not meet thresholds for Florida Healthy Start home visiting based on their screen, *Connect* staff can use their discretion to refer families with risk factors to the program if they express an interest in services. Florida Healthy Start home visiting offers this flexibility because it is considered a safety net for pregnant women and parenting families in Florida.

***Connect* workers also use a decision tree and knowledge of programs to match families to home visiting programs.** Well Family System algorithm only matches families to statewide home visiting programs. Therefore, as a complement to the algorithm, *Connect* staff can use a decision tree and their

[9] Statewide programs include Early Head Start, Florida Healthy Start, Healthy Families Florida, NFP, and PAT.

own knowledge of home visiting to match families to local home visiting programs, which are typically smaller, specialized programs that are not available statewide. Through regular communication with home visiting programs, *Connect* staff learn about the home visiting programs' capacity and the languages their staff speak.

Families can choose the home visiting program that best meets their needs. To promote family choice, *Connect* staff provide families with a description of the home visiting models they are eligible for.[10] Families that are eligible for more than one program select their preferred program. *Connect* staff confirm the name of the selected home visiting program on the call and may follow up with the family via text message or email with details. They also screen for and refer families to other supports in the community; these additional referrals are documented but sent and tracked outside of Well Family System.

> *"If I look at [Connect] as a clearinghouse, [Connect staff] can see—is this family with these needs more appropriate for PAT, [Heathy Families Florida], etc.? From that perspective, they have the best opportunity to refer to the best-fit program for that family."*
>
> — Home visiting staff

Referral to and coordination with home visiting programs

***Connect* staff aim to send referrals to home visiting programs within 72 hours of completing intake.** Typically, home visiting staff receive *Connect* referrals via Well Family System (including an email notification from *Connect* staff). If a home visiting program cannot receive referrals through Well Family System, *Connect* staff send an encrypted email with the completed intake form and any additional information. *Connect* staff may schedule a call between families and the home visiting program about enrollment. One *Connect* staff member remarked that families that agree to schedule these appointments are more likely to enroll in home visiting than those who simply receive a follow-up call from the home visiting program. Box III.4 shows referral numbers from *Connect* to the four home visiting programs we interviewed.

Box III.4. *Connect* referral numbers

The average monthly *Connect* referrals from programs interviewed include the following:

Broward Healthy Start Coalition

- Healthy Start (Program A): 160
- Healthy Start (Program B): 80

Healthy Start home visiting programs receive all of their referrals from *Connect*.

Well Florida Council

- PAT: 20 (about 95 percent of total referrals received)
- NFP: 10 (about 99 percent of total referrals received)

Home visiting programs typically attempt to contact families within five days of the referral and make three attempts. In some home visiting programs, supervisors may attempt the first contact before passing the referral to the home visitor, whereas other programs have home visitors immediately contact referrals.

Enrollment in Home Visiting Programs

Home visiting program staff reported that almost all *Connect* referrals are eligible for their program, and one program reported that about 20 percent of referred families enroll. Occasionally, a family is not eligible, or another program is a better fit, and *Connect* staff may work with the program to

[10] The model descriptions *Connect* staff use are provided by the home visiting programs in each coalition.

refer the family elsewhere with the family's consent. One home visiting program staff member thought the enrollment rate illustrated that, despite receiving a lot of *Connect* referrals, families may not be interested in home visiting services. Box III.5 describes families' experiences enrolling in home visiting.

Box III.5. Families' experiences with referral to and enrollment in home visiting through *Connect*

- All seven families said the handoff from *Connect* to the home visiting program was fast and easy, with most of them hearing from the program within a few weeks. One family reported hearing from *Connect* within days of confirming their pregnancy and received a call from the home visiting program that same week.
- Two families reported receiving a text message or email after speaking with *Connect* staff that contained information from the call, including details on the home visiting program they were referred to and next steps.
- Three families said they were offered a choice of programs while speaking with *Connect* staff.
- All seven families reported receiving simple, accurate program descriptions from *Connect*. After connecting with a home visitor, they received more detailed descriptions of the programs.

Documentation and Data Sharing

"The data system is the make or break for coordinating all these referrals that come in."

— *Connect* administrator

Statewide home visiting programs use Well Family System to update enrollment capacity, referral progress, and enrollment status. Well Family System tracks the number of referrals sent to each program from *Connect* and each program's remaining capacity, though home visiting programs regularly update *Connect* staff on their real-time capacity. *Connect* encourages home visiting programs to update referral outcomes, such as whether a family enrolled in home visiting, though this does not happen consistently. Smaller home visiting programs that are not available statewide typically do not have access to Well Family System, so *Connect* staff provide referrals and track enrollment status and capacity using encrypted emails.

Box III.6. Example information available by region and home visiting program

- Number of screens sent to *Connect*
- Number of referrals sent to *Connect*
- Number of referrals sent to each home visiting program
- Number of families enrolled in each home visiting program

Healthy Start MomCare Network, Inc. uses Well Family System data to monitor and report on *Connect* and home visiting programs. Multiple data elements can inform monitoring and reporting. Some of these elements are shown in Box III.6. *Connect* staff can access data for each home visiting program offered in their region. Home visiting programs view the status of every referral they have received from *Connect*, including whether the program contacted, enrolled, or closed a case within 90 days. They can also see this information in aggregate for other home visiting programs in their regions. Healthy Start MomCare Network, Inc. uses the information in Well Family System to conduct an annual county analysis to ensure referrals are distributed fairly across home visiting models. They also write an annual report and create ad hoc reports for legislators and funders to continuously advocate for *Connect*.

Family consent and data privacy are integral to *Connect*'s procedures. From screening to intake and enrollment, staff obtain family consent at every step of the process. The Department of Health requires all families to consent to have their information shared with *Connect*, and providers document this on risk

screens. Business associate agreements are in place between *Connect,* home visiting programs, and the Medicaid health plans to allow for legislatively mandated coordination with the Medicaid health plans. In Well Family System, users' access depends on their role. For example, only a few staff in each home visiting program can see confidential data on families referred to their program, and *Connect* staff can only view data in their regions.

Successes, Challenges, and Opportunities for Improvement

Successes

FAHSC, *Connect,* and home visiting staff noted the following successes:

- **Raising awareness of home visiting and other services across Florida.** *Connect* reaches hundreds of thousands of families across the state. Nearly all *Connect* and home visiting staff we spoke with felt that *Connect* does not leave any gaps or miss potentially eligible families. Even if families decline home visiting, *Connect* staff can share a range of resources with them.
- **Reducing competition for referrals and giving families more choices.** *Connect* provides a consistent referral stream for home visiting programs, helping to decrease competition between programs and concerns over filling their capacity. Centralizing referrals has allowed families to choose the program that best meets their needs, and organizations referring families to *Connect* know they will be connected to a program that meets their needs.
- **Strengthening partnerships and communication.** FAHSC, *Connect*, and home visiting staff all emphasized the importance of partnerships and communication in the successful implementation of *Connect*. Building *Connect* brought home visiting programs together to learn from one another and understand how to best serve families.

> *"All of the home visiting programs are stronger because we're getting the right clients for our programs. [We're] serving who we're supposed to be serving and having an impact on who we're supposed to be impacting."*
>
> — *Connect* staff

Challenges and opportunities for improvement

FAHSC, *Connect,* and home visiting staff noted the following challenges and opportunities for improvements:

- **Home visiting programs that are not statewide are not in Well Family System, which creates extra work for *Connect* staff.** *Connect* staff must use both an algorithm and a decision tree to select a match for families and then email these home visiting programs the referral information. In addition, they have to manually track referral outcomes for these home visiting programs in Well Family System.
- **Because Healthy Start coalitions implement *Connect*, other home visiting programs may perceive that *Connect* mostly refers to the Healthy Start home visiting program.** *Connect* staff work with home visiting programs to emphasize that *Connect* provides referrals to all home visiting programs, not just the Healthy Start model. Nevertheless, other home visiting programs may still recruit their own families, despite frequent reminders from coalitions and FAHSC about the difference.

> *"It's an extremely important model for coordinating home visiting in communities, and it continues to be worth the effort."*
>
> — *Connect* administrator

- **Funding has not kept pace with call volume.** Coalitions have seen an increase in *Connect* referrals and their responsibilities, but their funding has stayed the same. Staff from one coalition mentioned that some regions may find creative ways to supplement *Connect* funding, such as with local funds, though not every coalition has the resources to do so.

Florida is continually seeking to improve *Connect*. FAHSC, *Connect,* and home visiting staff shared the following opportunities for growth:

- **Obtaining complete family contact information.** *Connect* staff said missing or incomplete contact information in the automated Medicaid lists is a major challenge because it makes it difficult to reach the families. *Connect* has an agreement with the Department of Health for read-only access to certain parts of the data systems for WIC and Medicaid to try and fill in family contact information.
- **Implementing electronic prenatal screens to expedite referrals.** Prenatal screens, which were originally filed manually via paper forms, can take up to 30 days to reach *Connect* after being completed. FAHSC staff noted they were working toward implementing electronic prenatal screens in fall 2025 to expedite the process of sending prenatal screens to *Connect*.

Box III.7. Florida *Connect* case study participants

In Florida, we spoke with 21 participants about *Connect*:[11]

- Three centralized intake administrators for the state
- Nine people at **Broward Healthy Start Coalition**, including:
  - Three centralized intake administrators
  - Two home visiting supervisors/directors from one home visiting program that uses Florida's Healthy Start model
  - Four families that enrolled in Healthy Start home visiting through *Connect*
- Nine people from **Well Florida Council**, including:
  - Three centralized intake administrators
  - One home visiting supervisor and director from a home visiting program that uses the PAT model
  - Two home visitors from two home visiting programs that use the PAT and NFP models
  - Three families that enrolled in NFP home visiting through *Connect*

[11] The findings and conclusions in this summary are those of the authors and do not necessarily represent the official position of the Florida Department of Health.

This page has been left blank for double-sided printing.

IV. Indiana's *My Healthy Baby*

This case study describes Indiana's *My Healthy Baby (MHB*) system.[12] Box IV.1 lists key features of the system and Exhibit IV.1 summarizes *MHB's* process for referring pregnant women to home visiting.[13]

Box IV.1. Key features of Indiana's *MHB*

Launch date: 2020

Geographic scope: Statewide

Intended population: Pregnant women

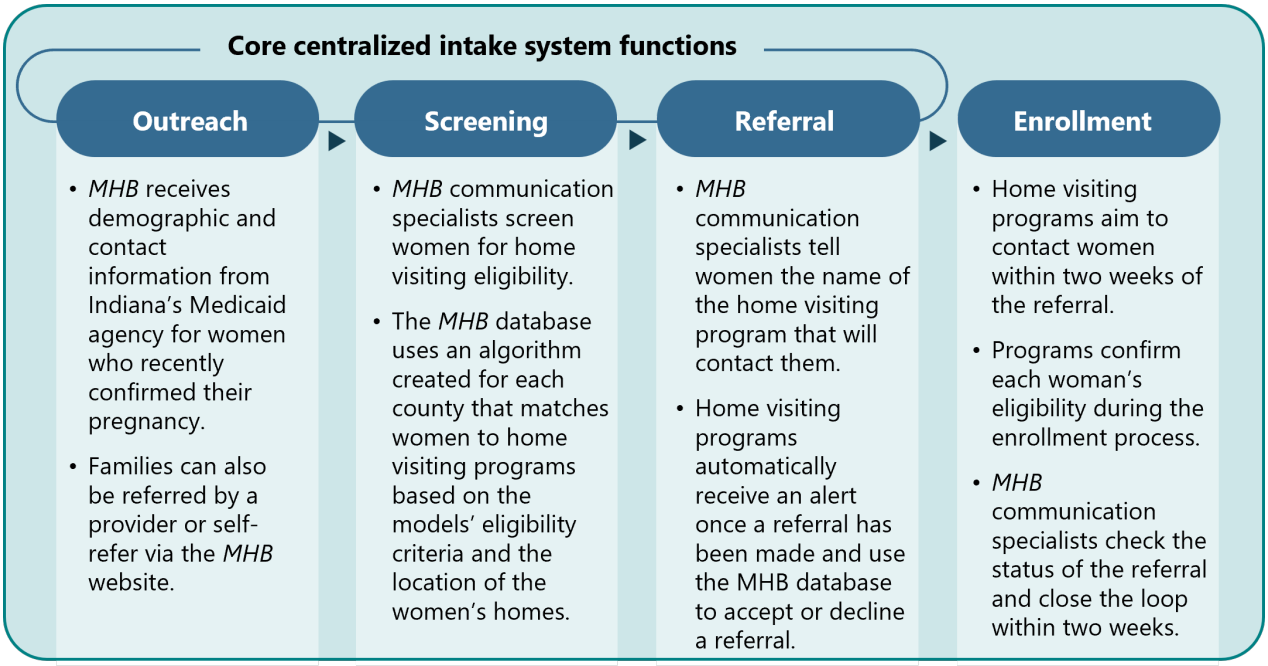
Number of employees: 25+

Home visiting models it refers to: Early Head Start, Healthy Families Indiana, Healthy Start, Nurse-Family Partnership, Parents as Teachers, and locally developed programs and models

Additional services offered by *MHB*: Information on concrete resources, food assistance, health care, child care, and case management

Funding sources: State funds and Medicaid funding

Exhibit IV.1. *MHB*'s process for referring pregnant women to home visiting programs



[12] We spoke with 24 people in Indiana about *MHB*: three centralized intake administrators and two communication specialist supervisors, 12 home visiting staff from two programs that use the Nurse-Family Partnership or Healthy Families Indiana model, and seven families from these home visiting programs.

[13] This case study refers to the intended population of *MHB* as "pregnant women" and the intended population of home visiting programs and the Moms Helpline, as well as case study participants, as "families."

Centralized Intake System Development and Goals

***MHB* aims to lower Indiana's infant mortality rate by strengthening coordinated referral pathways and reducing barriers to early access.**[14,xx] In 2019, Indiana's governor signed *MHB* into law, instructing the Indiana Department of Health (IDOH) to establish a perinatal navigator program to connect pregnant women with early prenatal care, wraparound services, and home visiting programs.[xxi] *MHB* launched in Allen County in January 2020. However, the plan was always for statewide reach, which was achieved in May 2023. Although *MHB*'s long-term goal is to support all pregnant women in Indiana, its focus as of 2025 is reaching women insured by or eligible for Medicaid. Goals such as increasing the capacity of home visiting programs and finding other data sources for identifying and contacting pregnant women have been added as the system continues to grow.

> *"[IDOH was] trying to change the stigma of home visiting, [so] that when a mom gets pregnant, they want her first [question] to be 'Who is my home visitor?'"*
>
> — Home visiting staff

***MHB* strives to achieve four goals it considers pillars of success.** These goals include:

1. Identifying and referring women for home visiting as early as possible in pregnancy
2. Supporting and strengthening perinatal home visiting programs and the home visiting system
3. Normalizing home visiting so women want to engage in home visiting services
4. Evaluating and improving internal processes and the home visiting network in Indiana

During the initial planning and start-up phases, state agency leaders met frequently with home visiting programs to establish the system and build relationships. *MHB* is a collaboration between IDOH, the Family and Social Services Administration (FSSA), and Department of Child Services (DCS), each bringing distinct roles in running the system (Box IV.2). Before launching, state leaders from these agencies met with staff from home visiting programs in every county to involve them in the process for deciding how they would receive referrals from *MHB*. One program reported verifying that the *MHB* algorithm, which assigns women to home visiting programs based on model eligibility criteria and the location of their home, had indeed distributed families to programs as intended.

Box IV.2. State agencies' roles in Indiana's *MHB*

- **IDOH** is the lead administrative agency of *MHB*.
- **DCS** funds the Healthy Families Indiana home visiting program.
- **FSSA** is the state Medicaid administrator and the main referral source for *MHB*.

***MHB* funds are state-legislated.** The annual state funding amount for *MHB* is $3.3 million. *MHB* receives funds from (1) state Obstetric Navigator funds, which are allocated by law and (2) Medicaid funding. These funds support more than 25 full-time staff members to run day-to-day operations and innovative initiatives to improve services across the state. *MHB* also provides grants that respond to the needs of home visiting programs—such as for additional prenatal training for Healthy Families Indiana programs following increased prenatal referrals.

[14] In 2019, the age-adjusted infant mortality rate in Indiana was 6.54 infant deaths per 1,000 live births, the 14th highest in the United States.

Structure and Operations

Administration and staffing

IDOH administers *MHB* under the Moms Helpline umbrella. The Moms Helpline is an IDOH information and referral service for Indiana families that are expecting or parenting young children. *MHB* is one component of the Moms Helpline that is specific to home visiting. Families that call the Moms Helpline receive information about prenatal care, pregnancy, parenting, infant and toddler development, where to get baby supplies, help finding a doctor or health insurance, and other resources.

***MHB* includes a team of over 25 staff, including the following:**

- **The director of community engagement and systems building,** who oversees the daily operations of *MHB* and the Moms Helpline.
- **The *MHB* project director,** who manages system funding and improvements and leads meetings with the data team, program supervisors, and representatives from IDOH, FSSA, and DCS.
- **A team of about 20 communication specialists,** who contact women to screen them for eligibility and make referrals to home visiting programs and community resources. All communication specialists answer calls for both *MHB* and the Moms Helpline; none specialize in only one or the other. Two supervisors oversee the communication specialists and manage and track outgoing referrals.
- **The *MHB* home visiting coordinator,** who liaises between the communication specialists and the home visiting programs and manages grants to home visiting programs.
- **A resource specialist,** who manages the *MHB* data system, including importing Medicaid data extracts.

Oversight

The *MHB* Advisory Committee supports the relationship between state agencies and home visiting programs. The Advisory Committee, established in 2020, is a coalition including every home visiting model in the state. The committee meets quarterly and discusses topics such as the expectations of home visiting programs, the referral process, data sharing, system enhancement, and any ongoing challenges. The committee helped develop the *MHB* Home Visiting Standards, which describe expectations for participating in *MHB*; collaborated on the terms of partner agreements; and provided input on the scripts that communication specialists use when discussing home visiting.[15]

The Indiana Early Childhood Collaborative reviews *MHB* monthly enrollment numbers and quarterly and annual reports.[16] This group was established in 2013 and is run jointly by IDOH and DCS. It is made up of home visiting and early childhood leaders throughout Indiana, including representatives from FSSA and IDOH. The board meets monthly to discuss home visiting efforts in Indiana.

[15] *MHB* Home Visiting Standards are nine required home visiting program standards to ensure *MHB* referrals have access to a core set of resources and support, regardless of home visiting model. Examples of standards include those related to program participation, family goal setting, and staffing and supervision.
[16] The collaborative was previously called the Indiana Home Visiting Advisory Board.

Outreach

***MHB* uses Medicaid data extracts, self-referrals, and referrals from providers to identify pregnant women and families for outreach.** Medicaid data contain demographic and contact information for women who have described themselves as newly pregnant on Medicaid applications. The communications specialists found nearly 90 percent of the women they called were identified through Medicaid data. Women can also self-refer to *MHB* by entering their information on a form on the system's website or by contacting the Moms Helpline. Providers also refer clients through the *MHB* website.

***MHB* has used various kinds of outreach and marketing to promote *MHB* and home visiting across Indiana.** *MHB* launched a large marketing campaign featuring billboards, social media, and short videos about participant experiences. This contributed to an increase in incoming calls and submissions of online self-referral forms. *MHB*'s community outreach team also attends events throughout Indiana to promote the Moms Helpline and *MHB*. In addition, home visiting programs conduct their own outreach, but home visiting programs reported they do not share *MHB* promotional materials when they do outreach. Box IV.3 summarizes how several families we spoke with heard about home visiting.

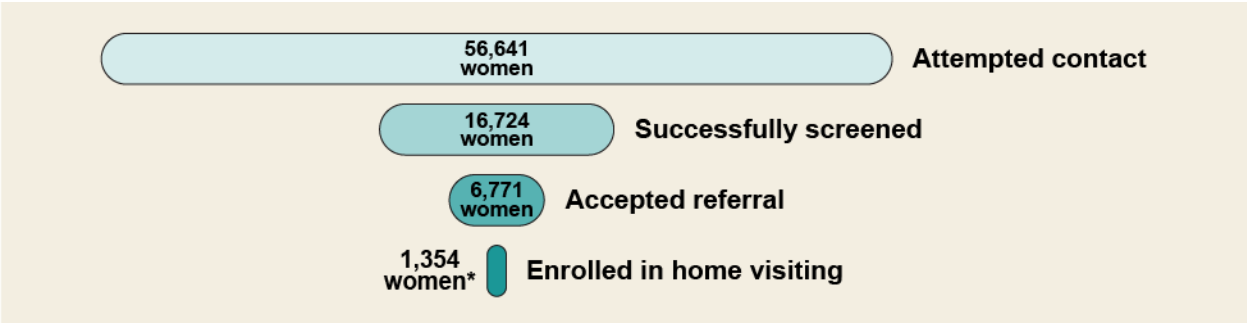
> *"Just be as down to earth and humble as possible … I think every family needs help. So if you can connect with them the way they need help, that would be good."*
>
> — Familv

Box IV.3. Families' perspectives on outreach

- Of the seven families we spoke with, four reported hearing about home visiting for the first time from a healthcare provider. Two reported hearing about home visiting from Medicaid (which likely refers to *MHB*), and one learned about home visiting during an appointment for food assistance.
- One family found out about home visiting from a family friend before receiving the call from *MHB*.
- Most families thought the process of outreach worked well, but some suggested additional methods might be helpful, such as more flyers, news ads, or public information about what home visiting entails.

Communications specialists make two calls to attempt to contact women. They screen roughly one-third of the women they call because some do not answer the call or choose not to confirm their identity or complete the screen. For those who do not answer or whose phone number does not work, they send an informational postcard. Exhibit IV.2 shows the number of women who were contacted, screened, referred, or enrolled through the system in 2023–2024. As the exhibit shows, although communications specialists received names and contact information for a large number of women, only a fraction of the women complete the screen, and only about 8 percent of those who are screened enroll in home visiting.

Exhibit IV.2. Indiana *MHB* outreach to women and enrollment in home visiting (July 2023–June 2024)[xxii]



* *MHB* staff reported that about 20 percent of the women who accepted a referral to home visiting go on to enroll in services, so this number is an estimate.

To maintain privacy and ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA), communication specialists first confirm the person they are calling's identity, then discuss home visiting. Verifying the person's identity safeguards against unintentionally revealing a pregnancy to a party other than the pregnant woman. The specialists follow a script that asks for the woman's name, explains they are working as a partner to Medicaid, and asks whether the woman is interested in learning more about "community resources to support families." After the woman confirms their details, the specialist introduces *MHB* and provides information about home visiting and other pregnancy support services. *MHB* staff reported that most women confirm their information right away. If the woman is hesitant, the specialist talks about the importance of verifying information to ensure privacy. They may suggest the woman call them back to show the number is legitimate or send an email so the woman can see the official .gov domain. In addition, *MHB* staff said most women proceed with the screening conversation once their identity is confirmed.

Screening and Referrals

Collecting information on families and matching them to a home visiting program

During the outreach call, communication specialists screen for program eligibility. They collect information about the woman's income, insurance coverage, visits to a doctor, and pregnancy, and make notes about family needs in the *MHB* data system. On average, calls take six to 10 minutes, though they may take longer if the conversation requires language interpretation. One interviewed family said their call took 30 to 40 minutes. One home visitor mentioned that the notes from *MHB* about extra needs or concerns can be helpful when reaching out to families.

The Helper App, embedded in the *MHB* data system, suggests up to three options for home visiting program matches. Communications specialists apply their knowledge of available programs and the family's needs to narrow the options. They may talk with women about which program they prefer. If staff cannot provide the name of the home visiting program during a call, they follow up with the woman via email. Before ending a call, communication specialists explain that the woman should hear from the home visiting program within the next

> *"If [the Helper App] gives us an agency, we can trust that."*
>
> — *MHB* staff

two weeks. Staff reported success with using the Helper App to match a woman to a program about 90 percent of the time.

Referral to and coordination with home visiting programs

Home visiting programs receive *MHB* referrals through automated email alerts and are expected to promptly contact families. Home visiting programs can access the *MHB* portal to see referrals, and many larger programs upload these referrals to internal data systems. The *MHB* partner agreement (described in Box IV.4) specifies the time frame in which home visiting partners must contact a family and close the referral loop by accepting a referral, declining it, or indicating the referral was sent to another program. If a program does not accept or decline a referral in the *MHB* data system within a week, *MHB* staff send the program a reminder. After two weeks, *MHB* declines the referral on the program's behalf and reassigns the case elsewhere. One home visiting program reported that about 25 percent of their referrals came from *MHB*. The other program estimated that 15 percent of their referrals (roughly 20 to 30 per month) were from *MHB*.

Box IV.4. Referral rules included in agreements with home visiting partners

- Accept or decline referrals in the *MHB* portal within two weeks
- Contact families within five days after receiving a referral from *MHB*
- Close the referral loop within two weeks
- Conduct background checks for all home visitors
- Provide services from pregnancy through at least the baby's first 12 months
- Participate in data sharing
- Meet the *MHB* Home Visiting Standards

***MHB* referrals may duplicate other referral sources.** Home visiting staff noted the same families could be in their system twice, with one home visitor estimating that about 40 percent of all *MHB* referrals were already known to the program. For example, women might first hear about home visiting through *MHB* outreach and then hear about home visiting again through a local program like the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Taking a positive perspective, staff noted that duplicate referrals at least show that women are being reached. Home visiting programs cited WIC offices, healthcare providers, local child welfare agencies, and word of mouth as other popular referral sources.

From the home visiting staff's point of view, there are few differences between referrals from *MHB* and other sources. One home visitor observed that the information from *MHB* can be less complete than information from other sources, although it is typically sufficient for making contact. Another home visitor noted that some women referred by *MHB* may not remember a lot about the program from the short call they have with the communications specialist, so home visitors may need to explain their program to potential families again.

Enrollment in Home Visiting Programs

Home visiting programs distribute the referrals to designated staff who reach out to families directly. Both the programs that we interviewed have designated staff that access referrals in the *MHB* data system and reach out to families. To reach referred women, home visiting program staff call, text, email, and send letters; some even mentioned stopping by people's homes. The staff explain briefly where the referral came from and schedule an in-person meeting to discuss enrollment. If a family is not eligible

for services, both of the programs refer them to another home visiting program in the area and not back to *MHB*. Box IV.5 describes families' experiences enrolling in home visiting.

Box IV.5. Families' experiences enrolling in home visiting through *MHB*

- Five of seven families did not know or remember whether they were referred through *MHB*. This is likely because the process of identifying pregnant women for *MHB* outreach mostly takes place behind the scenes, and *MHB* outreach messaging focuses on providing families with information about community resources to support them.
- Two of the seven families reported waiting two to three weeks between talking to *MHB* and beginning visits.
- Families said they felt comfortable sharing their information with staff from *MHB* and the home visiting programs.
- Most families noted they enrolled in home visiting because they wanted support with parenting as first-time parents. Other reasons included receiving tangible benefits, such as diapers and wipes, and being part of a community.
- All families remembered receiving an in-person assessment from their home visiting program. During these assessments, families had questions about scheduling visits, the frequency and duration of visits, and where the referral came from.
- Families said the home visiting programs gave similar or more detailed descriptions of their programs than the referral source had (*MHB* or another source).

Documentation and Data Sharing

The *MHB* data system receives Medicaid data and allows for bilateral data sharing between *MHB* and home visiting programs. *MHB* staff import Medicaid data into the *MHB* data systems. The data system stores information on families, community resources, program capacity, and referrals and enrollment. The *MHB* data system, which uses the VisionLink software platform, is shared by *MHB*, the Moms Helpline, and Indiana's 211 line.[17,18] Many larger home visiting programs' data systems interface with the *MHB* data system, enabling referral information in the *MHB* data system to automatically appear in the program databases. Further, the *MHB* data system includes more than 10,000 curated resources that communication specialists can share with families.[xxiii] *MHB* leadership meets biweekly with engineers to continuously improve the data system. For example, as of spring 2025, *MHB* was preparing to link *MHB* data to vital records data to analyze outcomes.

Home visiting programs submit monthly reports to *MHB* that the *MHB* resource specialist uses to update the data system manually. The reports cover program capacity, enrollment status, and reasons for not enrolling in home visiting. The home visiting programs whose data systems do not interface with the *MHB* data system use a manual portal to provide information. *MHB* regularly shares referrals with home visiting programs through its data system and can see when home visiting programs accept or decline a referral. Home visiting programs are only authorized to access referral information for their program. *MHB* has data sharing agreements with home visiting programs that collectively receive 95 percent or more of the referrals *MHB* sends to programs.

[17] Indiana 211 is a free service that connects Indiana residents to resources and supports in their local communities.

[18] VisionLink is a software platform commonly used for 211 systems. In Indiana, the Moms Helpline was already using VisionLink, and *MHB* gained access when it was embedded into Moms Helpline systems.

***MHB* follows HIPAA compliance standards and works with a legal team and state agency partners to ensure privacy is protected.** *MHB* keeps information private by encrypting emails to home visiting programs. When pregnant women apply for or enroll in Medicaid, they are asked to consent to receiving a call from *MHB*. Interviewed families said they had to consent to their information being shared, and some mentioned that staff talked about HIPAA. To ensure privacy, *MHB* also does not allow for text messaging or web chats about *MHB*, except to send texts to request a return call.

***MHB* shares data reports regularly with its staff, advisory groups, partner agencies, and the state legislature.** Quarterly and annual reports shared with IDOH, FSSA, and DCS discuss progress and performance toward the four pillars of success. *MHB* is also required to provide an annual report to the state legislature that includes evaluation of five metrics.[19] Reports to advisory groups cover information on successful contacts, referral acceptance, and enrollment by demographic information and geography. *MHB* staff, including communication specialists, also receive regular data updates related to their role, including the number of pregnant women reached, how many accepted a referral, and ongoing improvement efforts.

> *"I really enjoy getting that data. Calling people every day can feel redundant and lead to losing sight of the bigger picture. Seeing those numbers helps reinforce the understanding of what we're doing."*
>
> — *MHB* staff

Successes, Challenges, and Opportunities for Improvement

Successes

Noted successes included the following:

- **A system of support for home visiting programs throughout the state.** *MHB* staff reported progress toward their goal of strengthening partnerships with home visiting providers. Early in the initiative, *MHB* collaboratively engaged home visiting programs to design county-level referral processes. To sustain the collaboration, *MHB* continues to host regular advisory committee meetings, providing a forum for programs to build relationships, exchange knowledge, and share best practices.
- **Strong interagency collaboration.** *MHB* leadership agreed that the high level of collaboration between IDOH, FSSA, and DCS has been key to *MHB*'s success. Leadership and program staff from these agencies meet weekly. They combine their resources to work toward a common goal of connecting pregnant and parenting families to early prenatal care, wraparound services, and home visiting.

> *"There's no way a referral system can work if the people you're referring to don't want to work with you … On more than one occasion, our relationship with the home visiting [programs] has been the most important thing."*
>
> — *MHB* staff

[19] The five metrics are the number of people potentially eligible for home visiting; the percentage of them who were successfully contacted, accepted a referral, and opted out of a referral; and the percentage of them who were successfully contacted and accepted a referral, by demographic factors.

Challenges and opportunities for improvements

Noted challenges included the following:

- **Difficulty contacting women.** From July 2023 to June 2024, communication specialists successfully completed the screening process with roughly 30 percent of the women they attempted to contact (Exhibit IV.2). Communication specialists must verify a parent's identity before they can explain *MHB,* which can delay family engagement. Calls from *MHB* sometimes show as spam on families' phones, and some *MHB* staff said people may not answer calls from unknown numbers. In response, *MHB* communications specialists piloted making three call attempts instead of two to see whether it would improve the number of successful contacts. They were awaiting the results of this effort at the time of this study. Some *MHB* staff said the contact information they receive is outdated. One home visiting staff member expressed concern about not being able to reach women who do not have phones, such as unhoused women.
- **Concerns about future funding.** *MHB* staff voiced concern that their reliance on funding from the state budget and Medicaid makes them susceptible to changes in the priorities of each administration.

MHB staff embrace ongoing improvement and shared the following opportunities for growth:

- **More continuous quality improvement.** Communication specialists have participated in several kinds of continuous quality improvement, including one that focused on strengthening phone introduction scripts. *MHB* is also reviewing ways to increase team engagement among communication specialists and continually seeks new areas for improvement.
- **Providing home visiting program staff with more information about *MHB*.** Home visitors said they had little to no knowledge about what *MHB* is or what it does. Although one program reported prioritizing *MHB* referrals, their home visitors were unsure why that was the case. Home visiting staff said they did not receive formal training about what *MHB* is, and many said they would like more training on *MHB*.

This page has been left blank for double-sided printing.

V. Missouri's *Coordinated Referral and Intake System*

This case study describes Missouri's statewide *Coordinated Referral and Intake System (CRIS)*, which operates in five regions across the state. Specifically, we present findings from two regions (known as collective impact regions): Promise 1000 (the first collective impact region in the state, based in Kansas City, Missouri) and the Community Partnership of the Ozarks-Family Focused Network (based in Springfield, Missouri), hereafter Family Focused Network).[20,21] Box V.1 lists key features of the statewide *CRIS*, and Exhibit V.1 summarizes its process for referring families to home visiting.

Box V.1. Key features of Missouri's *CRIS*

Launch date: 2014

Geographic scope: Statewide, regional implementation

Intended population: Families eligible for home visiting

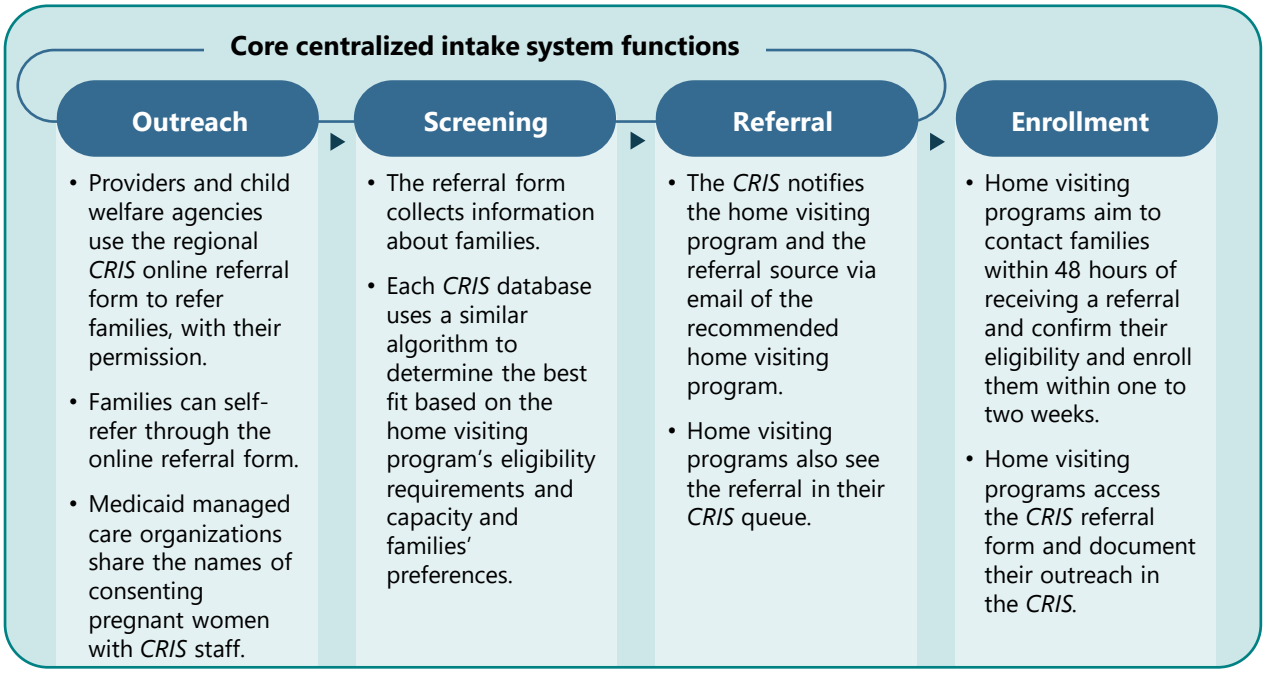
Number of employees: Approximately 10

Home visiting models included: Early Head Start, Healthy Families America, Parents as Teachers (PAT), Nurse-Family Partnership, Nurses for Newborns, Nurturing Parenting Program, and Team for Infants Exposed to Substance Use

Additional services offered by *CRIS*: Not applicable—*CRIS* only offers referrals to home visiting

Funding sources: State funds

Exhibit V.1. *CRIS*'s process for referring families to home visiting programs



[20] Collective impact work centers on advancing a common agenda, reporting on shared progress measures, engaging in mutually reinforcing activities, communicating continuously, and identifying lead organizations to coordinate efforts within a designated community or area.

[21] We spoke with 17 participants about the *CRIS*. Box V.5 has more information.

Centralized Intake System Development and Goals

The *CRIS* was developed to achieve two main goals:

- **Increase access to home visiting.** Staff at Children's Mercy Hospital in Kansas City learned that although there were several evidence-based home visiting programs operating in Kansas City, many providers did not know about them, did not know how to refer families to them, or did not know how to identify which ones could best meet families' differing needs. The hospital staff and local home visiting programs worked together to create Promise 1000 and build the *CRIS* data system in the Research Electronic Data Capture (REDCap) platform to help community partners refer families to the programs best aligned with their needs.

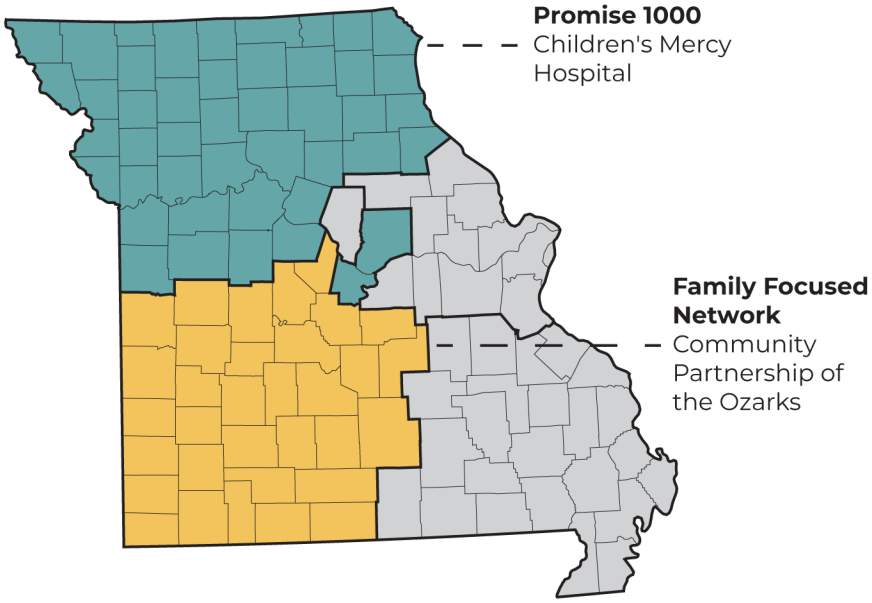
> *"Before, people got referrals from a lot of places, and not every referral partner knew about every program, so referrals were scattered. If you are a family, and someone says you should apply for home visiting services, they didn't always know where to go, or if they did, a program might be at capacity or not take them due to eligibility."*
>
> — *CRIS* administrator

- **Improve the health of families across Missouri.** The Children's Trust Fund, Missouri's quasi-governmental foundation for distributing funding to support programs that prevent child abuse, funds the *CRIS*.[22] They sought to capitalize on the Promise 1000 collective impact region's successes in Kansas City and expand the *CRIS*. State policy changes related to early childhood systems presented an opportunity for the *CRIS* to better engage families across Missouri in parent support and education, including increasing access to health care and educating families on maternal and child health. Family Focused Network's initial goal for participating in the *CRIS* was similar to the goal of the Promise 1000 collective impact region, which was to increase and improve referrals to home visiting.

The *CRIS* is one piece of Missouri's overall work on collective impact.[xxiv] Each of the five collective impact regions' lead organizations coordinates with home visiting programs in its area, provides data to the Children's Trust Fund, maintains a *CRIS* data system using REDCap software, and ensures all families referred to the *CRIS* are matched to a home visiting program. The collective impact lead organizations also provide standardized training to home visiting programs on a range of topics, such as core competencies for home visitors, and lead continuous quality improvement and data improvement for home visiting programs. The *CRIS* was based on a vision of maintaining a shared referral data system for home visiting and to drive continuous quality improvement. Exhibit V.2 outlines the five collective impact regions and shows the two collective impact regions—and the lead organizations that run them—that were included in the case study interviews.

[22] A quasi-governmental entity is established by a government agency to manage services while operating with a degree of independence similar to that of a nonprofit or private organization.

Exhibit V.2. Map of Missouri's collective impact regions that participated in the case study



Note: The graphic was adapted from a version designed by the Children's Trust Fund. The bold lines show the five CRIS regions across Missouri counties. The regions we interviewed for the case study are shown in color.

The timeline for developing the *CRIS* unfolded as follows:

- **Promise 1000 developed the initial infrastructure for the *CRIS* in Kansas City.** Staff from Children's Mercy Hospital attended a presentation in Ohio because they were interested in developing a similar system.[xxv] From 2012 to 2014, they created an office to support home visiting collective impact work and hired three personnel who became the Promise 1000 team.[23] Promise 1000 piloted a *CRIS* referral form and data system and gathered feedback from home visiting programs.[xxvi] From 2014 to 2016, Promise 1000 funded three home visiting programs to pilot the *CRIS* data system in their region.
- **Between 2016 and 2023, the Children's Trust Fund expanded collective impact work and *CRIS* statewide.** The Children's Trust Fund recognized the potential of Promise 1000's *CRIS* and sought to replicate the approach across the state as part of its focus on building systems to prevent child abuse. Family Focused Network in the Ozarks region responded to a Children's Trust Fund request for proposals to operate a collective impact region and established its *CRIS* in 2021. The Family Focused Network collaborated with home visiting programs to customize tools and identify *CRIS* partners.[24] To expand *CRIS* partnerships and reach, the Family Focused Network has made targeted efforts to inform all PAT programs in the collective impact region of the *CRIS*.[25] PAT is a key resource in the region's rural areas, where few other resources may be available.
- **As of 2025, five lead agencies operate collective impact regions that cover the state, each with a *CRIS* modeled after Promise 1000's system.** The five collective impact regions implement the *CRIS* in

[23] Promise 1000 was originally called the Kansas City Home Visiting Collective and focused on home visiting in the Kansas City metropolitan area.

[24] Home visiting programs that participate in the *CRIS* are considered *CRIS* partners.

[25] PAT was founded in Missouri, and every school district (about 500 in total) has a PAT home visiting program, but the characteristics of programs vary widely.

almost the same way. To meet local contexts and needs, each region uses its own referral form and *CRIS* data system, modeled closely on the original tools developed by Promise 1000. Collective impact regions use different strategies to identify *CRIS* partners. One collective impact region provides incentives to *CRIS* partners for completing referrals quickly, accompanying families on well-child visits, and participating in an advisory group and other collective impact activities, including collecting case management data.

The Children's Trust Fund is the primary *CRIS* funder. In 2022, the Children's Trust Fund secured a $1 million line item in the state legislature's annual budget for collective impact work, which includes the *CRIS* and other activities. For instance, home visiting programs that agree to share home visiting data with the Children's Trust Fund beyond the requirements of the *CRIS* (called "full data partners") receive a stipend for their involvement. The Children's Trust Fund divides the $1 million across the five collective impact regions, using a formula that considers factors such as region size and number and type of *CRIS* partners. Some collective impact regions also receive local grants to supplement the budget. The Children's Trust Fund budgets about $10,000 annually to maintain four *CRIS* data systems using REDCap software; Promise 1000 maintains its *CRIS* data system separately through Children's Mercy Hospital.

Structure and Operations

Administration and staffing

Two to three staff members oversee the *CRIS* in each collective impact region, with support from a data consultant. *CRIS* staff generally build and maintain partnerships with home visiting programs, sharing resources such as flyers and a recruitment and outreach toolkit on their website.[xxvii] The data consultant provides technical support to all five collective impact regions, including quarterly reviews of capacity and need for additional home visiting programs.

> *"Our goal has always been to scale up home visiting services, reaching a level of delivery service so that every family who needs the service can get it. If we can do this, we believe we can get to enough people affected by [home visiting], that we can see population-level health impacts. CRIS was the tool to get us to scale."*
>
> — *CRIS* administrator

***CRIS* staff in the regions invite home visiting programs to become *CRIS* partners.** *CRIS* partners sign an annual agreement to adhere to *CRIS* guidelines, including to receive referrals and to keep *CRIS* staff updated on eligibility and capacity. Typically, a home visiting director or supervisor monitors referrals in the system and participates in collective impact meetings. In 2025, Promise 1000 had 44 *CRIS* home visiting partners, and Family Focused Network had 20.

The training provided is determined by each collective impact region. *CRIS* and home visiting staff reported that minimal training was required to use the *CRIS* data system. Promise 1000 developed training modules on using the *CRIS* for *CRIS* partners. Family Focused Network does not have specific training materials but provides informal staff training to new *CRIS* partners.

Oversight

Collective impact regions participate in two regular meetings. First, the Children's Trust Fund holds a monthly meeting for all five collective impact regions. The regions provide feedback, share updates on referrals, and talk through challenges or successes with the *CRIS*. In addition, each collective impact region

meets monthly or bimonthly with its local *CRIS* partners and other community organizations. They discuss home visiting capacity and enrollment, *CRIS* outcomes, special topics, and opportunities for improvement in their region.

Outreach

Families are referred to the *CRIS* by three main sources:

- **Medical providers, including obstetrician-gynecologists, pediatrician offices, hospital case managers and social workers, and Medicaid managed care organizations.** The Children's Trust Fund works alongside Missouri's Medicaid program to ensure an effective partnership with the managed care organizations to increase referrals to the *CRIS*. One *CRIS* leader shared that the number of prenatal referrals sent to the *CRIS* in 2025 doubled from the previous year. Across the state, medical providers are a top referral source to the *CRIS*.
- **The Missouri Department of Social Services' Children's Division, the state child welfare agency.** Some contracts between home visiting programs and the Children's Trust Fund expect child welfare agencies to use the *CRIS* to refer families to home visiting. The *CRIS* helps home visiting programs meet these expectations by providing all Children's Division workers with one process for making home visiting referrals. Some staff said this is the most common pathway into the *CRIS*.

> *"From a referrer standpoint, researching and learning about capacity and eligibility is tedious and time-consuming. Our referrers don't have to know the capacity of programs or even the names of programs or eligibility. Once they put a referral in, it is almost guaranteed they will be matched and contacted by a home visiting provider."*
>
> — *CRIS* administrator

- **Community events, organizations, and businesses.** *CRIS* staff connect with families and local organizations at community events such as parent cafes, community baby showers, and back-to-school events. Particularly in rural areas, they must make extra efforts to reach families where they are, posting flyers in laundromats, libraries, grocery stores, and convenience stores. *CRIS* staff also give presentations to community organizations, such as schools, to increase awareness of *CRIS* and promote referral partnerships, and they share talking points and marketing materials with partners. Full data partners also receive iPads to enroll families. Families can also self-refer to the *CRIS* by completing the online *CRIS* referral form for their region. Promise 1000 receives some self-referrals, but staff at the Family Focused Network noted that self-referrals were uncommon in their region. Box V.2 shows the families' perspectives on home visiting outreach.

Box V.2. Family perspectives on home visiting outreach

- Of the six families that participated in the case study, two first learned about home visiting through the Children's Division, one from a school, and three through medical organizations (for example, hospitals, clinics) or a Medicaid managed care organization.
- Two families completed the online *CRIS* referral form themselves and thought the process was straightforward.
- One family appreciated the opportunity to use an iPad to complete the *CRIS* referral form while at a community event, saying, "At the [community] closet event, I signed up on a tablet, and they helped me fill out the paperwork. [The home visitor] gave me her number and said she'd get a hold of me to schedule an appointment because … I signed up in front of her, which was very convenient."

Screening and Referrals

Collecting information on families and matching them to a home visiting program

Collective impact regions designed the online *CRIS* referral forms to efficiently collect information. *CRIS* referral forms collect a range of information, including families' contact details, demographic characteristics, and experience with home visiting. The referral forms are available in English, Spanish, and French. Families and providers can indicate their preference for a specific home visiting program on the form. *CRIS* and home visiting staff estimate the referral form takes about five minutes to complete.

An algorithm embedded in the *CRIS* data system instantly matches families to home visiting programs. The algorithm uses information from the referral form and aligns it with program eligibility requirements such as pregnancy status, child's age, geographic residence, and special concerns such as substance use. The algorithm also applies a round-robin approach to balance referrals across home visiting programs. If a family is eligible for multiple home visiting programs that have capacity, this approach ensures referrals go to the programs that did not recently receive a referral. If a match is not automatically detected, *CRIS* staff match families to programs manually. Each collective impact region can tailor the algorithm to align with regional needs and priorities. *CRIS* staff do not contact families directly unless they need more information to match the family to a home visiting program. Families, *CRIS* staff, and home visiting program staff reported that the *CRIS* generally matches families to programs they are eligible for, suggesting the algorithm works the way it is supposed to across regions.

Organizations that refer families to the *CRIS* receive email notifications when families have been referred to home visiting. Although referring agencies cannot access the *CRIS* data system directly, they can receive an email when families are contacted by home visiting programs and may know whether families enroll or decline to participate in home visiting.

Referral to and coordination with home visiting programs

Across all five collective impact regions, 133 home visiting programs participate in the *CRIS*. One *CRIS* administrator noted that in 2025, the *CRIS* processed 2,580 referrals across Missouri (42 percent of whom accepted home visiting services). However, the number of *CRIS* referrals to home visiting programs varies within and across collective impact regions. In the Promise 1000 region, one staff member at a home visiting program said they receive as many as 40 *CRIS* referrals per month and estimated that nearly all their enrolled families come through the *CRIS*. In contrast, in the Family Focused Network region, one home visiting program received about five *CRIS* referrals per month and estimated that less than 10 percent of its enrolled families came through the *CRIS*. However, for a second home visiting program in that region, all families had enrolled through *CRIS* referrals (nine at the time of the interview). The *CRIS* serves as one referral source for home visiting programs and some *CRIS* partners continue to recruit and enroll families directly into their programs without using the *CRIS*.

The *CRIS* data system sends email notifications and reminders to home visiting programs about families in their queue. Immediately after the *CRIS* data system matches a family to a home visiting program, the designated contacts at the home visiting program receive an automated email. The designated contacts see all active referrals in their *CRIS* queue. The *CRIS* data system also sends home visiting programs an email reminder every seven days if they have not updated the referral status. *CRIS* staff may follow up with home visiting programs that do not update the *CRIS* or initiate contact in the

expected time frame. If a referred family is not contacted within about a month, *CRIS* staff will generally reassign the family to another program.

Enrollment in Home Visiting Programs

Home visiting programs contact families to determine eligibility and enroll them. *CRIS* guidelines require home visiting programs to make initial contact within two business days of receiving a referral. In one program, supervisors first contact families to confirm their interest and then ask home visitors to follow up with the family to enroll them. In another program, home visitors conduct the initial outreach and enrollment with families. In all three home visiting programs interviewed, home visitors make up to four contact attempts before declining the referral in the *CRIS*. Box V.3 shows the families' experiences with referrals and enrollment in home visiting programs.

Home visiting staff document the referral outcome in the *CRIS* data system. Home visitors often track their contact attempts in external spreadsheets, and then supervisors update the *CRIS* data system with information about their outreach attempts. If a family is not eligible, *CRIS* staff reassign the referral to another program. Most home visiting programs aim to enroll families within a week or two of contacting them, but it may take longer if they have problems reaching a family.

Box V.3. Families' experiences with referrals and enrollment in home visiting programs

- Three families that were referred to home visiting through medical organizations were not aware the *CRIS* was part of their enrollment process. This is to be expected because the *CRIS* referral form is usually completed by the referrer, and families in Missouri do not typically interact with *CRIS* staff as part of the referral process.
- Two families noted that, once connected to the home visitor, the home visiting program provided a helpful explanation of home visiting services. However, one family thought they were going to receive more support for skills beyond parenting (such as mental health services and budgeting).

Documentation and Data Sharing

Promise 1000's *CRIS* data system was built using Children's Mercy Hospital's existing REDCap software license and is easily adaptable to meet local needs. Collective impact regions continue to adapt the system based on feedback from *CRIS* partners. For example, *CRIS* staff created a dashboard so home visiting programs could easily track assigned referrals. Some home visiting programs can now run their own reports about referrals and enrollment through the *CRIS* data system.

"We are constantly improving the database. We built it with home visiting in mind and with home visiting input. It's adaptable because it's in REDCap, and we have a programmer on the team. Anytime we need to make an update, we can."

— *CRIS* administrator

The *CRIS* data system was designed to protect family privacy by restricting access to referral information. Home visiting programs can only see information about families referred to them. If a program declines a referral, the family's information is cleared from the *CRIS* queue.

Collective impact regions compile reports for the Children's Trust Fund (Box V.4). The Children's Trust Fund uses data from quarterly reports to oversee the system and to discuss implementation with collective impact regions. Staff at the Children's Trust Fund also use a *CRIS* capacity map to identify counties that may have challenges with activities such as matching families to home visiting programs. In addition, the Children's Trust Fund presents *CRIS* outcomes during collective impact and quarterly outcome ratings meetings.[26]

Box V.4. Collective impact regional data shared with the Children's Trust Fund

- Time to contact families
- Time to enroll families in home visiting
- Number of referrals from various referral sources
- Number of families waiting in the queue
- Number of home visiting referrals accepted
- Number of home visiting program declines and reasons for decline (from families or programs)

Successes, Challenges, and Opportunities for Improvement

Successes

The Children's Trust Fund, *CRIS*, and home visiting staff noted the following successes:

- **The *CRIS* helps create a common language for and understanding of home visiting outreach, referral, and enrollment.** Staff noted that *CRIS* and the broader collective impact work created a common home visiting language for organizations that serve young children and families. Home visiting programs and other organizations that refer to *CRIS* meet regularly to discuss family needs, experiences with the *CRIS*, and community updates that influence the *CRIS*. Organizations that refer to the *CRIS* believe that the *CRIS* helps families connect to home visiting.

> *"It does cut down on the need for competition; it's just wherever a family matches unless you specify otherwise … All the big groups throughout the state have a common language of CRIS."*
>
> — Home visiting staff

- **A collective impact approach helps promote a shared vision and supported *CRIS* and home visiting staff buy-in to the *CRIS*.** They continue to share feedback, promoting the collective effort to develop a prevention-based system. This approach also promotes communication and connection among the home visiting programs, which share and learn from one another; this is especially helpful in rural areas, where programs can feel isolated.

Challenges and opportunities for improvement

The Children's Trust Fund and *CRIS* staff noted two challenges and opportunities for improvement:

- **Although the *CRIS* works efficiently in some communities, other areas are still building their *CRIS* partner network.** Staff agreed that statewide uptake of the *CRIS* is a work in progress, especially in rural areas or the regions that have adopted the *CRIS* more recently. As noted, not all home visiting programs participate in the *CRIS*. If more programs participate, there will be more opportunities to match families to the programs that best fit their needs and preferences. In addition, in the Family Focused Network, some *CRIS* partners still primarily conduct outreach for their own programs, and one partner noted that it does not typically share the *CRIS* link when reaching out to families in the area.

[26] The Children's Trust Fund conducts quarterly meetings with 22 home visiting programs that participate in its Outcomes Rate Card initiative, which rewards home visiting programs for meeting key metrics.

Instead, this partner directs families to sign up on their program's website. Thus, in some regions, the level of collaboration with the *CRIS* could be improved to help make the *CRIS* more impactful. In addition, some providers may still not know how to refer families through the *CRIS*.

- ***CRIS* data systems could hold more information.** Because some home visiting programs receive referrals through avenues outside of the *CRIS*, *CRIS* staff do not always know how many families enter different home visiting programs. Because they only have information on families that are referred through the *CRIS*, and on the home visiting program's capacity, regions are challenged to understand the scope of home visiting uptake when looking at *CRIS* data. In addition, because some programs maintain internal systems for tracking referrals, they may be slow to update that information, so the *CRIS* is not always current. Furthermore, the Children's Trust Fund staff noted that ideally, they would like to be able to communicate and assess the impact of an increased uptake of home visiting referrals on health outcomes. Given that *CRIS* partners are not required to collect data in the *CRIS* after the referral is made (only full data partners do this), even with the growing Medicaid partnership, the Children's Trust Fund cannot accurately assess impacts in regions or across the state based on *CRIS* data alone.

Box V.5. Missouri *CRIS* participants

In Missouri, we spoke with 17 participants about the *CRIS*:

- Two statewide administrators
- Seven people in the Promise 1000 collective impact region, including:
  - One centralized intake administrator
  - Three home visiting supervisors or directors from one home visiting program that uses the PAT model
  - Three families that enrolled in home visiting through the *CRIS*
- Eight people in the Family Focused Network collective impact region, including:
  - Two centralized intake administrators
  - Two home visiting supervisors/directors from one program that uses the PAT model
  - One staff member from a home visiting program that uses the Healthy Families America model
  - Three families that enrolled in home visiting through the *CRIS*

This page has been left blank for double-sided printing.

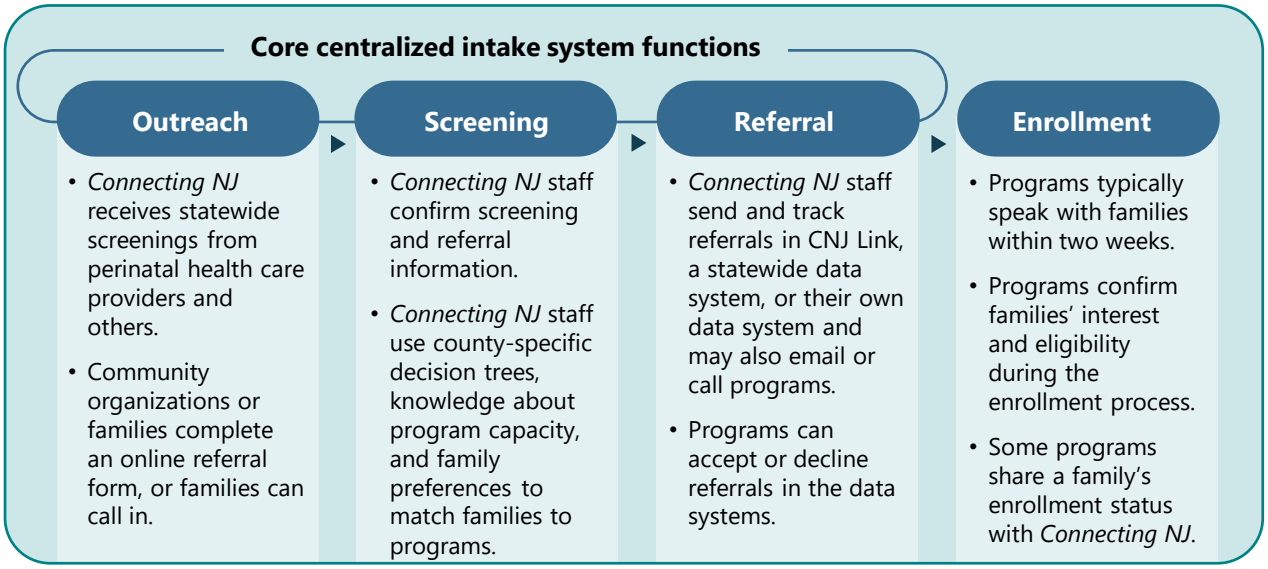
VI. New Jersey's *Connecting NJ*

This summary describes *Connecting NJ*, a statewide centralized intake system that operates through seven lead agencies across all New Jersey's 21 counties. It is a county-based system, with lead agency staff forming partnerships and making referrals based on services available in each county. Findings represent data collected on the statewide system and two lead agencies: Central Jersey Family Health Consortium (CJFHC) and Project-Self-Sufficiency (PSS).[27] Box VI.1 shows the key features of *Connecting NJ*, and we summarize *Connecting NJ's* process for referring families to home visiting in Exhibit VI.1.

Box VI.1. Key features of *Connecting NJ*

- **Launch date:** Pilot in 2010, statewide by 2015
- **Geographic scope:** Statewide, regional implementation
- **Intended population:** Parents and caregivers with children ages prenatal to 5
- **Number of employees:** 26 intake specialists and program managers at seven lead agencies
- **Home visiting models it refers to:** Healthy Families (HF), Nurse-Family Partnership (NFP), and Parents as Teachers (PAT)[28]
- **Additional services offered by *Connecting NJ*:** Short- and long-term case management and health education; support with child development, including developmental screenings; and referrals to community resources (such as concrete supports and food assistance)
- **Funding sources:** State funds and federal grants, including the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program and the Early Childhood Comprehensive Systems Program

Exhibit VI.1. *Connecting NJ*'s process for referring families to home visiting programs



[27] We spoke with 23 participants about *Connecting NJ*. Box VI.6 has details.

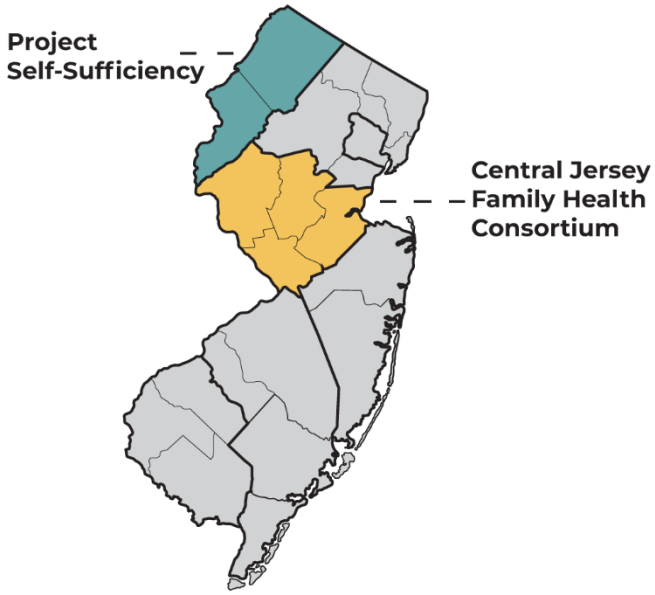
[28] Additional home visiting programs (such as Family Connects NJ and Early Head Start) are available in certain counties.

Centralized Intake System Development and Goals

County and state leaders initially developed *Connecting NJ* as a single point of entry for home visiting. As state and MIECHV-funded home visiting expanded in New Jersey beginning around 2010, some home visiting program leaders and administrators in the state's Department of Children and Families (DCF) wanted to evenly distribute home visiting referrals across programs and help families connect to the programs that best fit their needs. They also aimed to limit service duplication and improve the use of available resources.[xxviii]

New Jersey DCF and the Department of Health (DOH) developed and jointly operate *Connecting NJ.* DCF began investing in centralized intake as early as 2007 and piloted the current system in one county in 2010. DCF funded the system in other counties over time, and with funding from DOH, the system achieved statewide reach in 2015.[xxviii] Seven lead agencies, which also provide direct services, won contracts with DCF and/or DOH to operate centralized intake in assigned counties. (Exhibit VI.2 shows an outline of which counties are in the seven regions.)[29] Although DCF was the driving force behind *Connecting NJ*, start-up involved cross-agency collaboration between the state's maternal and early childhood systems leaders and a champion from DCF who saw an opportunity to bring them together. For further support, New Jersey became an affiliate of Help Me Grow, a national model for family-focused centralized systems.[30] Becoming a Help Me Grow affiliate provided *Connecting NJ* with a framework for systems integration, technical assistance, and features like a centralized phone system.

Exhibit VI.2. Map of *Connecting NJ* lead agencies that participated in the case study[xxix]



Note: The bold lines show the seven *Connecting NJ* regions across New Jersey counties. We name the lead agencies we interviewed for the case study and show their regions in color.

[29] CJFHC and PSS also have DCF contracts to operate home visiting programs in certain counties. For example, as of 2025, PSS is the provider for HF, NFP, and PAT in one of its *Connecting NJ* counties. PSS is also the NFP and PAT provider in a county where CJFHC administers *Connecting NJ*.

[30] More than 30 states are associated with the Help Me Grow National Center, a national system to comprehensively support families with children ages birth to 5. The model includes a centralized access point, family and community outreach, outreach to children's healthcare providers, and data collection and analysis.

As funding opportunities expanded, the system evolved from providing home visiting intake to offering a system of care. In 2019, New Jersey's first lady launched a cross-agency strategic planning effort. This effort focused on the state's need to improve maternal and child health outcomes and recommended ways to expand county centralized intake systems to do so.[xxx] Specifically, as grant funding became available, DCF and DOH added short-term, phone-based case management; long-term, in-person case management with health education; developmental screenings and other support for children (including to help develop plans of safe care).[31] These services offer alternative maternal and child health supports when home visiting programs are full or when families are not eligible for or interested in home visiting.

DCF and DOH braid multiple funding sources to jointly fund *Connecting NJ*. DCF and DOH jointly fund the staff who screen and refer families (called intake specialists) by issuing separate, county-specific contracts with lead agencies.[32] DCF also funds and oversees short-term case managers and child development staff, whereas DOH funds and oversees long-term case management. In addition to federal and state home visiting funds, the state has used federal Early Childhood Comprehensive Systems Program grants and Title V Maternal and Child Health Services Block Grants to pay for two DCF and two DOH staff to oversee *Connecting NJ* as part of their responsibilities; the former grant also funds lead agencies to build capacity for conducting continuous quality improvement (CQI) with home visiting programs. Past federal grants have also helped New Jersey build and expand the system, including a Preschool Development Grant—Birth Through Five.

Structure and Operations

Administration and staffing

All lead agencies operate *Connecting NJ*'s core central intake function through two positions:

- **A program manager** oversees system implementation and monitoring in the contracted counties. The program manager supervises intake specialists and coordinates with home visiting and other programs in the county. These duties include creating formal partnerships with each county's HF, NFP, and PAT programs and any other available and interested programs (including other home visiting programs and services such as doulas; Box VI.2).[33] Formal partners sign business agreements that outline *Connecting NJ* intake responsibilities. Other responsibilities of the program manager vary based on the scale of their agency and region. Exhibit VI.3 summarizes *Connecting NJ's* operational structure.

Box VI.2. *Connecting NJ* formal partners and other service providers

Connecting NJ manages and tracks referrals to **formal partners**, known in the state as hub partners. *Connecting NJ* staff communicate with formal partners about program capacity, referrals, data, and overall system performance. Formal partners have access to CNJ Link, *Connecting NJ's* statewide data system. In contrast, *Connecting NJ* staff inform families about other service providers in the county, and families contact them directly.

[31] Plans of safe care address the safety and well-being of substance-exposed infants, as required by the Child Abuse Prevention and Treatment Act.

[32] For example, CJFHC has a DCF contract for intake specialists in two of its counties and a DOH contract for intake specialists in the other two counties.

[33] New Jersey funds HF, NFP, and PAT in all 21 counties.

- **Intake specialists** (sometimes referred to as resource specialists) are families' first point of contact with *Connecting NJ*. The intake specialists receive referrals and contact, screen, and link referred families to home visiting or other community supports. Lead agencies typically have one intake specialist per county, who may liaise with the home visiting partners in an assigned county and specialize in understanding the county's resources.[34] In addition, at PSS, volunteers support the intake specialists by entering data.

Exhibit VI.3. *Connecting NJ* structure



Lead agencies staff community outreach to match the scale of their service areas and agency cultures rather than having a dedicated outreach role. For instance, supervisors and leadership at PSS (which administers *Connecting NJ* in two counties) conduct community outreach to support all of PSS's services, although all PSS staff have some outreach responsibilities. In contrast, *Connecting NJ* staff at CJFHC (which administers *Connecting NJ* in four densely populated counties) stopped conducting community outreach. Instead, they rely on outreach staff from a universal home visiting program model, Family Connects NJ. Family Connects NJ outreach staff focus on the home visiting program model but are stationed at lead agencies. Their coordination and co-location with *Connecting NJ* has freed up time for CJFHC intake specialists to attend to a large and growing volume of referrals.[35,xxxi]

Oversight

DCF and DOH co-run statewide quarterly meetings and communicate as needed with lead agencies:

- **At *Connecting NJ* meetings,** which include supervisors and direct services staff from lead agencies (including intake, case management and child development roles, and Family Connects NJ outreach staff), DCF and DOH share policy updates, training, and best practices for implementing *Connecting NJ* and promote peer-to-peer learning.
- **At CQI meetings,** managers from *Connecting NJ* and home visiting programs develop a CQI project to implement based on performance metrics in their data dashboard. For example, PSS studied whether conducting intake with families in the office would improve home visiting recruitment.
- **Ad hoc communication** occurs often between *Connecting NJ* managers and supervisors and DCF and DOH staff who oversee *Connecting NJ*. DCF and DOH staff coordinate with and monitor the lead agencies they contract with for intake.

[34] One lead agency has one intake specialist to cover three counties (Cumberland, Gloucester, and Salem).

[35] Family Connects NJ offers resources and linkages to all families in a county within the first two weeks after a child's birth. Given their overlapping missions, Family Connects NJ outreach staff coordinate closely with *Connecting NJ* staff. Family Connects NJ rollout began in certain counties in 2024.

Lead agencies or home visiting programs may facilitate two county-level meetings with the following representatives:

- ***Connecting NJ* staff meet with their formal partners** to discuss program capacity, referral and enrollment data, and any challenges in the referral process in the county. At CJFHC, the program manager leads quarterly meetings with *Connecting NJ* intake and direct services staff (such as case managers) and home visiting supervisors. PSS, a smaller agency, communicates frequently with home visiting programs and does not have scheduled meetings.
- **Service providers (including formal partners), family members, and *Connecting NJ* staff** participate in quarterly community advisory board meetings in each county to strengthen the network of family support providers, exchange feedback, discuss community needs, and offer occasional training on a topic (such as safe sleep). Home visiting programs also promote openings for families and upcoming community events. In PSS's counties, home visiting and *Connecting NJ* managers co-facilitate these meetings. In CJFHC's counties, Family Connects NJ outreach staff facilitate the meetings.

Outreach

State and local pathways connect families to *Connecting NJ*. Home visiting programs rely on *Connecting NJ* for referrals to varying degrees, but *Connecting NJ* tracks all referrals, even when families directly contact programs. Overall, the main referral pathways to *Connecting NJ* and home visiting programs are as follows:

- **Two statewide screening and referral systems systematically link families to *Connecting NJ:*** (1) perinatal care providers complete perinatal risk assessments with pregnant women, primarily Medicaid clients,[36,xxxii] and (2) community health workers, hospitals, child welfare agencies, and others can complete community health screenings for women or men regardless of their parenting status.[37,xxxiii] Both types of screenings are transmitted, with client consent, directly into CNJ Link, which *Connecting NJ* developed for this purpose.
- **Word of mouth among existing clients** is common; two programs said it is their main referral source. For example, families mostly call PSS's main number for supplies or assistance and are then directed to *Connecting NJ* intake specialists to be screened for home visiting or other services. At a PAT program in CJFHC's region, an estimated 70 to 80 percent of families call PAT directly, usually after hearing about it from other PAT families.
- **Community outreach** by some home visiting staff (depending on model requirements and openings) and some lead agency staff includes speaking with organizations and families at community advisory board meetings, offices, and events and places where families congregate. Family Connects NJ outreach staff also raise awareness for *Connecting NJ* services.
- **Public agencies and other service providers** in child welfare, primary prevention, and public benefits systems routinely refer families directly to home visiting programs or to *Connecting NJ*.

Once *Connecting NJ* receives a referral, an intake specialist aims to contact families within 48 hours. When families are referred directly to *Connecting NJ*, intake specialists explain the home visiting services and other resources available in the county, highlighting that services are free and voluntary.

[36] Medicaid plans are required to reimburse providers for completing these assessments.

[37] Although not its focus, *Connecting NJ* can assist adults before they start a family.

Building trust during these calls is paramount, especially for families that may not realize their health care provider referred them and are unaware of *Connecting NJ* or home visiting. Box VI.3 describes families' experiences finding out about home visiting.

Box VI.3. Family perspectives on outreach

- All five families that participated in the study were connected to home visiting through *Connecting NJ*. Although none of them were aware of *Connecting NJ* by name, they were familiar with the lead agencies whose staff they spoke with.
- Three of the five families found *Connecting NJ* through their perinatal provider—two completed a perinatal risk assessment and the third completed the online *Connecting NJ* referral form after seeing a flyer at a birthing hospital. One family learned about home visiting at the lead agency's food pantry and one learned about it searching for resources online.
- Speaking with *Connecting NJ* staff was quick, easy, and informative for all the families. Three noted feeling positive about the information they received, with one saying, "They made sure I understood everything before I agreed to it all" and it felt "like talking to a friend."
- Three families would have liked more information from their perinatal provider to help them understand what to expect from *Connecting NJ* and home visiting. For example, one suggested an email ahead of the phone call from the *Connecting NJ* intake specialist so she could check the legitimacy of the information: "I feel like if I received an email explaining some of the things and then a [centralized intake] phone call, then it would be like, I heard about [*Connecting NJ*]. [The phone call was] my first time hearing about the program. Not knowing they would call me and [having] someone telling you: 'Oh, I have this amazing program…' It was like way too many things that were too good."
- Two families suggested generally expanding outreach across the community, and another recommended social media advertisement so families could easily share them with their networks.

Screening and Referrals

Collecting information on families and matching them to a home visiting program

Intake specialists screen families they contact and match them to formal home visiting partners. Intake specialists from both lead agencies use their agency's intake form or script to confirm referral information and learn about families' needs and potential eligibility for and interest in home visiting and other services. When available, they draw on information in the screening forms, the *Connecting NJ* referral form, and client histories recorded in CNJ Link (or their own data system). The screening can be done directly in CNJ Link, although PSS uses its own paper-based intake form. If families contact a home visiting program directly, home visiting program supervisors may collect the screening information and securely email or fax it to a *Connecting NJ* liaison (an intake specialist or manager). The liaison then logs it in CNJ Link and assigns the family to the program without ever contacting the family; this way, all referral data are tracked in CNJ Link.

***Connecting NJ* intake specialists or managers use county-specific decision trees to match families to programs.** Decision trees are intended to help distribute referrals fairly across county programs. They account for model eligibility (such as gestational or child's age) and potentially municipality and referral source (such as child welfare or public assistance offices). In practice, however, one *Connecting NJ* manager said, "Four of five programs may not be accepting [new families]," and matching is based on conversations with program supervisors and families to see "what's available and what a family really

needs." Family requests are honored when possible, even if it means deviating from the decision tree. Intake specialists tell families to expect a call from the program they are matched with. If no home visiting programs have openings or families are not eligible or interested, families can be matched to *Connecting NJ's* case management or child development services. Staff also provide information on various community resources.

Referral to and coordination with home visiting programs

***Connecting NJ* staff use CNJ Link or alternative communication protocols to send referrals to formal home visiting partners.** PSS, for example, uses both CNJ Link and its own data system for referrals to its agency's internal home visiting programs. This requires double data entry but gives PSS a single, comprehensive client record across all its programs along with a backup for CNJ Link. Home visiting programs can see an alert in CNJ Link (or other data systems they use) when they have a referral. *Connecting NJ* staff may also email home visiting programs to alert them to referrals, especially if families' needs are urgent. Programs can accept or decline a referral in CNJ Link or other data systems they use. Programs may decline referrals, for example, if they are at capacity (overall or if the home visitors who speak the family's language have full caseloads) or if they cannot reach the family after multiple attempts. Two home visiting programs in one interviewed region report families' enrollment outcome to close the loop, whereas two programs in the other region report total numbers of families that enrolled, declined, or were unreachable.

> *"They are very good at connecting [families] to programs that have enrollments. The biggest turn-off to a family is referring them to a service that can't serve them and the best thing [Connecting NJ] does is [help to] avoid this—they're removing some of the major research that a family would have to do."*
>
> — Home visiting program supervisor

Further communication between *Connecting NJ* and home visiting staff takes place through phone, email, and CNJ Link. Staff from all interviewed agencies and programs agreed that although CNJ Link is effective for tracking referrals, "personal connection works more than anything." For formal home visiting program partners outside the lead agencies, frequent communication with an assigned liaison has been essential to trust-building and timely follow-up from home visiting supervisors. Home visiting programs affiliated with CJFHC also send monthly capacity reports (for openings overall and by language), which have streamlined the email traffic between the lead agency and programs for new referrals.

Enrollment in Home Visiting Programs

Home visiting programs promptly contact families to complete enrollment processes. Supervisors receive the referrals, and they or their staff follow up with the families. Programs start trying to reach out to families within 48 hours. Staff from two programs said it takes about two weeks to reach a family (via call, text, email, visits) and they stop trying after a month. For the home visiting programs housed at PSS, PSS intake specialists use their access to their home visiting colleagues' calendars and schedule a family's program enrollment visit during the screening call, eliminating the need for an additional call to families. Box VI.4 reports families' experiences being referred to and enrolling in home visiting.

> *"[The handoff] went amazing, it was probably the easiest process of a lot of the things I've had to do."*
>
> — Family

Most families that *Connecting NJ* refers to home visiting ultimately enroll, according to staff from all programs. Common reasons why families decline home visiting include concerns about the time commitment and having someone in their home. The latter is of particular concern for families referred through child welfare agencies and families whose primary language is Spanish.

Box VI.4. Families' experiences with referrals and enrollment in home visiting programs

- All five families interviewed thought the handoff from *Connecting NJ* to the home visiting program was fast and easy. They all said the home visiting program called them within a couple of weeks; one of them received a call in three days. One family recalled receiving a summary email with program information from *Connecting NJ* staff, then a text from the home visitor to schedule an enrollment visit.
- All families said they received simple, accurate program descriptions from *Connecting NJ* and more comprehensive descriptions from home visiting program staff.
- Three families chose to enroll in home visiting because they were first-time parents and wanted extra help and guidance on caring for a child; one mom was initially interested in supplies and linkages to resources; and another wanted developmental support.

Documentation and Data Sharing

CNJ Link's connectivity with other data systems and access for formal home visiting partners streamlines information sharing. Three key features stand out. First, because the data systems for perinatal risk assessments and community health screenings are connected with CNJ Link, *Connecting NJ* staff receive them automatically, with family permission. Second, home visiting supervisors can view referred clients' records in CNJ Link (including screening forms and *Connecting NJ's* contact history), update the referral status, and add new clients to CNJ Link when families contact them directly, although they may prefer to securely email client information to their *Connecting NJ* liaison.[xxxiv] Third, because referrals for some programs (HF and PAT) made in CNJ Link automatically show up in a separate, statewide data system for these programs, supervisors from these programs can see and update the status of referrals in these systems without using CNJ Link. For example, one HF supervisor interviewed only views and updates *Connecting NJ* referral statuses in the HF program data system.

CNJ Link's capability extends beyond referral tracking. Intake specialists, case management staff, and Family Connects NJ outreach staff record details about every family encounter and outreach activity they conduct. Outreach staff also maintain a resource directory in CNJ Link, which intake specialists can use when referring families to community resources. The resource directory is built into the FindHelp platform.

***Connecting NJ* maintains family privacy through formal agreements, access limitations, training on Health Insurance Portability and Accountability Act (HIPAA) compliance standards, and communicating with families on how data will be shared.** *Connecting NJ* lead agencies and formal home visiting partners sign a data use and business associates agreement with the CNJ Link vendor to access the system.[38] Lead agencies and designated home visiting program staff (typically supervisors) have role-based secure access to enter and view family-level data. NJ DOH and DCF have read-only access to CNJ Link for summary data and aggregate reports, which they use for program monitoring, development, and reporting.[xxxv] At each step from referral through enrollment, families give verbal or written consent before information is shared.

[38] A business associates agreement is used when HIPAA-covered entities exchange personal health information.

Monitoring and reporting on *Connecting NJ* takes place at the county and state levels. Reviewing data for accuracy and performance is a main purpose of the lead agency–led *Connecting NJ* partner meetings and the DCF and DOH-led quarterly meetings (Box VI.5). Lead agencies also compile and submit quarterly, county-level reports to DOH and/or DCF, depending on which agency funds their intake specialists. Over time, DCF and DOH reduced reporting burden by aligning their quarterly reports so lead agencies funded by both state agencies would complete identical reports. Still, one *Connecting NJ* manager noted their lead agency submits 17 distinct quarterly, county-level reports across multiple counties and system roles (which include intake, short-term case management, and child development support—each contracted separately), and the reports are time-consuming. The reports also draw on home visiting program data. Data dashboards in CNJ Link also help lead agencies, DCF, and DOH monitor ongoing performance. The dashboards aggregate data on eight performance measures for a glimpse of referral sources, the time it takes to initiate family contact, the time it takes to enroll in a home visiting program, and other metrics.

Box VI.5. Sample data elements monitored in meetings or reports

- Total number of referrals received
- Referral status (including whether a home visiting program accepts a referral, and recruitment status)
- Enrollment outcome (including the total number of families enrolled in home visiting)
- Service linkages
- Family demographics

Successes, Challenges, and Opportunities for Improvement

Successes

Staff highlighted the value of partnership at state and local levels and the benefits of centralizing intake:

- **Strong partnership between DCF and DOH.** By braiding funds, the state expanded *Connecting NJ* from home visiting intake to a more comprehensive system in which intake staff co-locate with case management and child development staff. In addition, DCF and DOH's alignment on reporting requirements enables consistent operations regardless of funder. Developing a cohesive, collaborative approach between DCF and DOH required much relationship building and identifying win-wins for both agencies and home visiting programs. Agency staff built on their experience working together on the state's MIECHV Program and other interdepartmental initiatives.
- **A culture of data capacity and improvement.** *Connecting NJ* and home visiting leaders appreciate the need to track referrals and performance measures. Managers in CJFHC and PSS also praised the ongoing support they receive from DCF and DOH. The state's commitment to CQI has fostered a "spirit of learning" that "trickles down to different agencies," according to one manager. Another described CQI meetings as a judgment-free space to analyze data, address challenges, and learn from one another. This culture of improvement flows from a mutual desire to help families and benefits from the state's continued financial investments in centralized intake.
- **Closer ties between county early childhood providers.** Working within a county-based partnership creates opportunities for home visiting and other providers to network and learn from one another, advertise openings and upcoming events, and strengthen communication. Staff in multiple organizations and roles noted that meetings and ad hoc conversations have helped home visiting providers come together around a shared mission of supporting families and begin to let go of a competitive mindset.

- **Ability to reach more families.** For two of the interviewed home visiting programs, centralizing intake has freed up staff time to focus on families instead of outreach. "Without them, we would not be able to meet our targets," one home visiting supervisor said. As noted, integration with the statewide screening systems makes it efficient to centralize referrals, particularly for densely populated counties.

> *"The very hardest thing in nonprofits is to get a symbiotic relationship … It can be cutthroat … It's getting there. Personal relationships … have helped greatly. You're getting that through the [community advisory board, and Connecting NJ meetings], or people actually meeting each other."*
>
> — Home visiting program supervisor

Challenges and opportunities for improvement

Noted challenges included the following:

- **Low funding for intake specialists.** Funding for this role has been flat for 12 years, according to one *Connecting NJ* manager, and the position is high stress, making it difficult to recruit and retain qualified staff. To alleviate this, PSS matches the state funding almost dollar-for-dollar to offer higher salaries and has volunteers help with the workload; both agencies offer incentives to staff to help retain them.
- **CNJ Link limitations.** At one lead agency, compiling data for reports is time-intensive and requires reconciling data from CNJ Link and the home visiting programs. This lead agency manager also runs multiple CNJ Link reports to follow the trajectory of cases across *Connecting NJ* services. Staff at the other lead agency double-enter data into their own electronic records system, in part to make it easier to track clients across programs.

Staff shared the following ideas for continuing to improve *Connecting NJ*:

- **Support for improving the quality of risk assessment referrals.** Often, intake specialists cannot reach families referred through the screenings due to incomplete contact information or because families were not aware they were referred and not expecting a call from *Connecting NJ*. This may be especially true of referrals from large, regional hospital systems. Managers at both agencies observed that ongoing training and relationship building with hospital staff helps improve the quality of referrals, but one agency manager noted staff no longer have time for this. This manager thought referral quality might improve if state staff either guided the agency on working with the hospitals or supported hospitals directly.

> *"A lot of [trust building] happens behind the scenes and before we meet with clients … It involves explaining the benefits of connecting families to [Connecting NJ] and making sure that they can communicate [to families] in a way that the family is already prepped to pick up [the phone]."*
>
> — *Connecting NJ* manager

- **Streamlined communication with DCF and DOH.** All *Connecting NJ* managers praised the level of support from their state partners, although those from one lead agency thought the flow of information could be more streamlined by, for example, having a single state liaison.

- **Use of CNJ Link data for local information sharing and planning.** State staff use CNJ Link's rich data to inform needs assessments and strategic plans.[xxxvi] One lead agency manager thought state partners could also share data back with home visiting and other community leaders on the families they serve and their service needs.

Box VI.6. *Connecting NJ* participants

In New Jersey, we spoke with 23 people about *Connecting NJ:*

- One centralized intake administrator at the New Jersey DCF
- Eight centralized intake administrators or staff from CJFHC and two administrators from PSS
- Four home visiting directors or staff from two programs in a CJFHC only–administered county and three staff from two programs in both CJFHC- and PSS-administered counties; the home visiting programs use HF, NFP, and PAT models
- Five families at NFP or PAT programs in CJFHC- or PSS-administered counties.

This page has been left blank for double-sided printing.

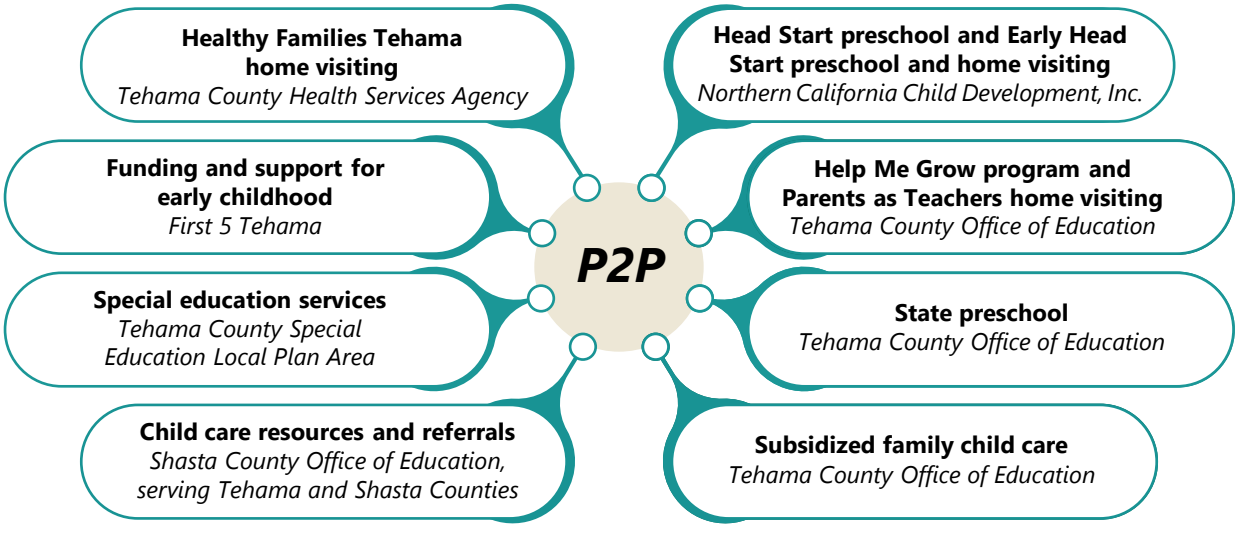
VII. Tehama County's *Pregnancy to Preschool Partnership*

This summary describes Tehama County's *Pregnancy to Preschool Partnership* (*P2P*).[39] Unlike the other centralized intake systems in this study, *P2P* is a collaborative referral network, not a single entity, and it is county-developed and implemented, not a statewide system. Exhibit VII.1 shows the early care and education service providers—referred to as *P2P* partners—that make up the *P2P* network. *P2P* partners developed and use a common screening and referral process and shared data system to refer families to home visiting programs and other services in the *P2P* network (Exhibit VII.2). In this system, multiple providers are responsible for screening, but like a centralizing entity, they distribute referrals using a single process. Box VII.1 lists other key features of the system.

Box VII.1. Key features of *P2P*

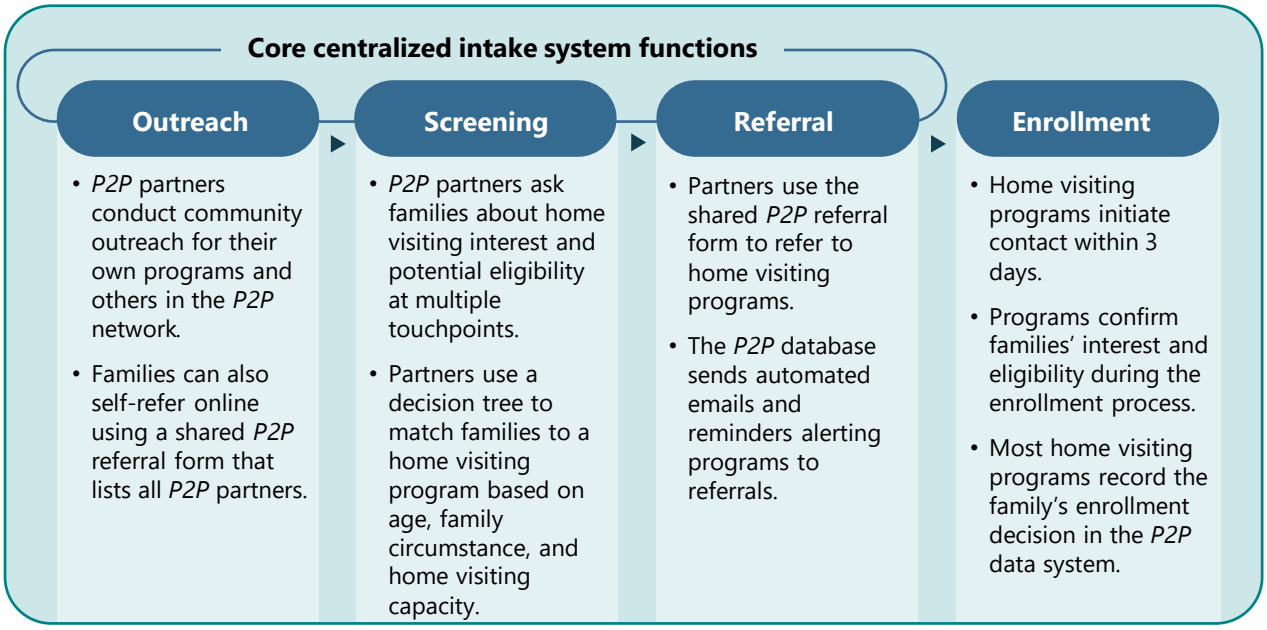
- **Launch date:** 2017
- **Geographic scope:** Tehama County, California—a rural, inland agricultural county in northern California, about two hours north of Sacramento.
- **Intended population:** Families with children from the prenatal period through age 5
- **Number of employees:** *P2P* does not have dedicated employees. Instead, seven early care and education providers in the county regularly meet and refer to one another, with assistance from First 5 Tehama, which convenes partners and contracts with an evaluation coordinator to manage and report on data; this referral network is called *P2P*.
- **Home visiting models it refers to:** Early Head Start (EHS), Healthy Families Tehama (HFT), and Parents as Teachers
- **Additional services offered by *P2P*:** Subsidized preschool, child care subsidies, child care, developmental screening, special education, and navigation support
- **Funding sources:** First 5 Tehama uses funding from the California Children and Families Act to support *P2P*; other *P2P* partners volunteer their time.

Exhibit VII.1. *P2P* partner organizations and their services



[39] In Tehama County, we spoke with 13 people: one centralized intake administrator, eight home visiting staff from two programs that use the HFT or EHS model, and four families.

Exhibit VII.2. *P2P*'s process for referring families to home visiting programs



Centralized Intake System Development and Goals

***P2P*'s goals are rooted in a collective impact approach to centralized intake and a formal agreement between the partners to refer families to each other's programs.**[40] As a collaborative referral network in a rural county, Tehama County leaders developed *P2P* to achieve the following objectives:

- **Better meet families' needs.** At any given time, some county services (such as a home visiting program) have availability whereas other services (such as a different home visiting program or preschool) may have a waiting list. Leaders from Tehama County home visiting programs and First 5 Tehama (referred to as *P2P* leaders) realized that families could be better supported elsewhere while they wait.[41] They also envisioned *P2P* partners could learn about and promote the service that best meets each family's needs, even if it means not filling a slot in their own program.

> *"I feel like our community has come a long way in that it's not just about getting somebody on our wait list, but let's get them served somewhere."*
>
> — *P2P* leader

- **Improve awareness of home visiting and early intervention services.** *P2P* leaders hoped that positioning more providers to share the value of home visiting with families would lead to more

[40] Collective impact work centers on advancing a common agenda, reporting on shared progress measures, engaging in mutually reinforcing activities, communicating continuously, and identifying lead organizations to coordinate efforts within a designated community or area.

[41] Because only one interview was conducted with First 5 Tehama (which administers the system), this summary attributes quotes and sentiments to *P2P* leaders instead of distinguishing between home visiting and centralized intake administrators.

consistent referrals. They also hoped *P2P* would increase referrals for developmental screenings and ultimately, early intervention services for eligible families.

- **Streamline service access.** Instead of expecting families to learn about each service, make an inquiry, and apply for the service, leaders envisioned a No Wrong Door approach, in which families could go to any *P2P* partner for help in figuring out which service to apply to.

***P2P* began in 2017 through conversations between directors of HFT, Head Start and EHS, and First 5 Tehama.** As HFT was starting up, the organization's director hoped to strengthen communication with other home visiting programs, avoid duplication, and share best practices. First 5 Tehama agreed to convene and organize all the public early care and education providers in the county serving families with children through age 5, including home visiting, child care, and preschool providers (Exhibit VII.1). First 5 Tehama also contracted with an evaluator to build a *P2P* data system (using Microsoft Dynamics 365 software) and support ongoing data monitoring. Partners met for more than a year to solidify a shared vision for *P2P*, develop a shared referral form, and agree on a decision tree to direct referrals. To formalize the partnership and enable data sharing, they signed a formal agreement.

***P2P* receives minimal funding, relying on partners to volunteer their time.** As of 2025, First 5 Tehama allocates about $18,000 a year from its funding under the California Children and Families Act.[42,xxxvii] These funds pay for a part-time contract with an external evaluation coordinator to manage the *P2P* data system, monitor data, and report on data at *P2P* meetings; and they also pay for some of the First 5 Tehama director's time. The First 5 Tehama director spends an estimated 10 hours a month on *P2P*-specific activities, and home visiting leaders who were interviewed estimated spending a couple of hours per month to a couple of hours per week each, depending on their roles and referral volume, with the start-up phase requiring more time. These leaders said the current funding is enough to support *P2P,* but they could make improvements with more funding.

Structure and Operations

Administration and staffing

As a collaborative, partners jointly administer *P2P*. The First 5 Tehama director leads *P2P* meetings and oversees the evaluation coordinator, but all partners are responsible for referring families to *P2P* services, tracking referrals, and attending *P2P* meetings. A shared referral form, linked to the *P2P* data system, enables cross-referrals. The two-page form is also available on First 5 Tehama's website or as a paper copy.[xxxviii] It collects parents' contact information and describes the *P2P* services and providers. The referring partner (or the family, if self-referring) simply checks the box next to the service(s) of interest to the family.

[42] The California Children and Families Act (Proposition 10) established First 5 California to support and promote early childhood development through coordinated programs that emphasize children's health, parent education, child care, and other services and programs for children from the prenatal stage through age 5.

Oversight

***P2P* meetings take place every other month and serve two purposes:**

- **Reviewing the status of referrals and program updates.** Managers from each partner try to attend meetings as often as possible, as do staff who conduct outreach, enrollment, and data entry. By one estimate, at least 20 staff members across partners regularly attend *P2P* meetings. Partners share program updates, current capacity levels, and opportunities for community outreach and professional development (such as training on promoting infant mental health). The evaluation coordinator shares data and works to ensure data quality (such as by reviewing data entries that are incomplete or may not be accurate). Staff at both home visiting programs interviewed for the study noted that the meetings are helpful for sharing information and building relationships.
- **Identifying and responding to community needs.** *P2P* partners consider how they can "partner together to better support families…and go over where there are gaps in [early care and education] services," as one *P2P* leader noted. They share firsthand accounts and community-level data to strategize matters affecting the county, such as rates of teen pregnancy or prenatal substance use.

First 5 Tehama shares *P2P* data and decisions with the Early Intervention Partnership, and information shared at Early Intervention Partnership meetings informs *P2P*. Led by First 5 Tehama, the Early Intervention Partnership is made up of county decision-makers working on mental health, physical health, and education initiatives for children younger than age 8. The group meets quarterly to discuss and support *P2P* and other county initiatives, needs, and resources.

Home Visiting Collaborative meetings also inform *P2P*'s approach to reaching families. Led by HFT, the Home Visiting Collaborative brings together home visiting program staff, parents, prenatal care providers, and community members every two months to strengthen home visiting practice and reach.

Outreach

Because *P2P* is a collaborative, partners share responsibility for outreach. Partners promote other *P2P* services while conducting outreach or enrollment for their own programs.[43] For example, home visiting partners said that if they cannot serve a family due to the family's ineligibility or the program's capacity, they share the *P2P* brochure or referral form with the family and offer to connect them to other programs. Within the *P2P* partner network, HFT program staff thought the Help Me Grow program (a *P2P* partner) was typically their main referral source, whereas EHS staff thought their *P2P* referrals were mostly from providers of special education services.[44] Box VII.2 describes families' experiences finding out about home visiting.

Home visiting programs also build awareness within and beyond the *P2P* network to obtain referrals. Programs develop networks through (1) agreements with local social services offices—such as Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), California Work

[43] Only First 5 Tehama, which does not directly serve families, conducts outreach on behalf of all *P2P* services, bringing on extra staff to attend community outreach events when needed.

[44] Tehama County's Help Me Grow program differs from the Help Me Grow national model for centralized access discussed in the Delaware and New Jersey case summaries. The Help Me Grow Tehama program conducts child developmental screenings and offers parents navigation support.

Opportunity and Responsibility to Kids, and child welfare agencies—to refer families or spread the word;[45] (2) community events, such as resource fairs, bilingual story hour, and festivals; and (3) networking with other community organizations, committees, or boards. Home visitors routinely educate *P2P* and non-*P2P* partners about home visiting, including how to talk about home visiting with families and differentiating home visitor support from child welfare services. With high turnover in public agencies, home visiting staff noted they "have to take [their program pitch] on a road show on a regular basis."

Box VII.2. Family perspectives on outreach

- Three of the four families interviewed described connecting to home visiting through a *P2P* partner. One was directed to home visiting services while looking for a free car seat at a Head Start site; one learned about EHS from an EHS staff member while working at a restaurant; and one parent worked next to the First 5 Tehama office and spoke with a First 5 Tehama staff member after encouragement from another community partner.
- One family reported learning about home visiting from hospital staff after giving birth.
- Two parents said that programs could do even more to get the word out, given that many parents in their networks do not know about home visiting. They suggested increased advertising through better-known programs, such as WIC, and at community events with free resources and food for parents. As one parent put it: "I feel like everyone knows about WIC just from word of mouth, but somehow no one seems to know about this [home visiting] program."

Screening and Referrals

Collecting information on families and matching them to a home visiting program

***P2P* partners gauge families' interest in and potential eligibility for home visiting at different points of contact,** including at outreach events, at enrollment appointments, when reviewing their waiting lists, and after services begin and new needs arise. EHS staff, for instance, tend to raise the possibility of a cross-referral as they learn more from a family during the EHS enrollment interview. Staff from all *P2P* partners interviewed explained that screening happens conversationally, without a formal tool or script. They described finding organic ways to ask families whether they know about home visiting, to explain it to them, to inquire about a parent's due date or children's ages, and to gauge the family's interest.

To decide which home visiting program to refer to, *P2P* partners use a decision tree and their knowledge about a program's capacity gained from *P2P* meetings. Before applying the decision tree, the home visiting programs consider their own program for families that self-refer or are referred to them. The decision tree considers model eligibility criteria for gestational or child age and the programs' comparative strengths. Expectant families and those with complex needs are directed to HFT because the model begins during the prenatal period and offers intensive case management, whereas families seeking preschool are prioritized for EHS home visiting, a stepping stone to center-based EHS or Head Start. If a *P2P* partner is not sure what service is best, they refer families to the Help Me Grow program, which offers child developmental screening and linkages to all families. Box VII.3 shows the total number of referrals *P2P* partners sent to and received from one another between July 2024 and June 2025.[xxxix]

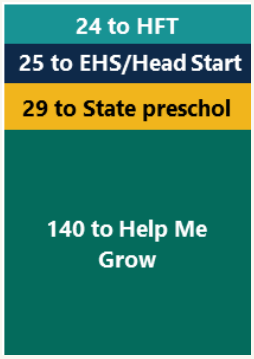
[45] Community referral partners outside *P2P* may make referrals using the shared *P2P* referral form but are not required to do so.

Referral to and coordination with home visiting programs

Referrals are sent electronically to the partner(s) selected in the referral form. Initially, only one partner could be selected, but forms now allow multiple selections to give families quicker access to more supports. Most partners complete the referral form directly in the *P2P* data system or on the First 5 Tehama website. Web-based referral forms are automatically emailed to the selected partners and must be entered into the *P2P* data system. Due to privacy regulations, HFT receives referrals through the *P2P* data system but manually sends referrals to other *P2P* partners by phone, email, or fax because they cannot share client information in the *P2P* data system.[46] If multiple partners are selected on a referral form, they may coordinate their follow-up with families to avoid simultaneous outreach but do not need to. In both home visiting programs interviewed, supervisors receive and assign referrals to an outreach specialist or home visitor to proceed with enrollment.

Box VII.3. Outcome of *P2P* referrals, July 1 2024–June 30, 2025

- 43 self-referrals through the *P2P* web-based referral form
- 223 referrals (on behalf of 165 parents or caregivers) sent between *P2P* partners (shown in bar chart)
- 61 percent of the *P2P* partner referrals (137 of 223) successfully enrolled in a service or received requested resources



Source: First 5 Tehama Annual Report 2024–2025.

Note: Five other referrals (not shown in bar chart) were to subsidized, licensed home-based family child care.

The *P2P* referral form serves as a release of information. Families sign the form, granting permission for partners to share their contact information and interest in services. Home visiting staff interviewed also inform families they will be sharing their information confidentially with *P2P* partners.

Enrollment in Home Visiting Programs

Home visiting staff attempt to contact families promptly to determine their interest and eligibility. *P2P* partners are expected to contact families within three business days, although there is no funding to facilitate compliance and one program staff member observed that another *P2P* partner often takes longer. Connecting with a family, program staff noted, can take a week or two, with another week or so to hold a meeting or receive paperwork, and even longer if a family is facing challenging circumstances (such as unstable housing) or if their phone number is not current (Box VII.4 summarizes families' experiences enrolling in home visiting). Program staff then follow their own enrollment processes and guidelines for follow-up attempts, screening, and enrollment. Most partners communicate the outcome of a referral in the *P2P* data system.

[46] As a service of a public health agency, HFT is governed by the Health Insurance Portability and Accountability Act (HIPAA) and regulations from Healthy Families America, the national office that oversees the program model. These rules prevent HFT from sharing any information on clients in the *P2P* data system, where partners can view all client information even for clients not assigned to them. This includes whether a family enrolls in HFT or HFT refers them elsewhere. HFT contributes aggregate data on family enrollment instead.

Box VII.4. Families' experiences with referrals and enrollment in home visiting

- Two of the four families interviewed were referred to home visiting through another *P2P* partner. They both said connecting to the program was quick and easy. The *P2P* partner staff they spoke with made them feel comfortable sharing personal information and coordinated multiple referrals on their behalf, leading to successful connections within a month.
- Enrolling in home visiting was straightforward and simple for all four families. Families shared that the programs called or emailed them to confirm their interest and schedule an enrollment visit. Staff then met families in their homes to complete paperwork and receive screenings in the families' preferred language (English or Spanish). Two families recalled being told they were eligible at the end of the first visit.
- Three families shared that information to help them care for their children and foster their development, and the space to talk about their concerns, motivated them to enroll or stay in home visiting.

Families referred through *P2P* may have a clearer understanding of what home visiting entails. One HFT staff member explained that when someone from *P2P* helps families complete the *P2P* referral form, they explain what the family is agreeing to—more so than other community providers do. Staff from this program also thought *P2P* referrals were easier to contact because the family was expecting their call.

Documentation and Data Sharing

To access the *P2P* data system, partners signed a data sharing agreement to protect family privacy. This was necessary because every referral is visible to all partners, including ones assigned to a different provider. Only one or two staff members per organization are granted log-in credentials. Only one *P2P* partner did not sign the agreement and cannot use the data system.[47]

Linkage between the *P2P* referral form and data system enables the following:

- **Automated emails that notify and remind partners that they have a referral.** Some referrers mentioned they still call or email the partner to confirm receipt or to find out what they can do for a family that needs help right away. Reminder emails are sent every five days, which, according to staff, helps ensure follow-through even though completing the enrollment process often takes up to 30 days.
- **Closing the loop on most *P2P* referrals.** Tracking the outcome of a referral is one of the main purposes of the *P2P* data system. Partners with access can see whether a referred family is ultimately served and together can monitor the overall performance of *P2P*.

> *"We wanted to know if we're serving these families that are getting referred. It's nice that [families] have easy access, but if we're not actually [serving them], what are we doing?"*
>
> — *P2P* leader

[47] A child care resource and referral provider based in another county did not sign the agreement.

- **Data monitoring and reporting,** which is the main way to hold partners accountable to the referral goals of the collaborative. The evaluation coordinator reviews the *P2P* data system monthly and emails any partners with an open referral to prompt them to update the referral status. This also supports follow-through and data accuracy. The evaluator shares reports with aggregate counts during *P2P* meetings so *P2P* partners can assess their collective performance, which all interviewed *P2P* leaders noted as a strength of *P2P* (Box VII.5). Detailed tracking also helps partners strategize. First 5 Tehama staff also underscored that *P2P* data help them understand the scope of their early care and education investments in the county and inform future funding decisions. One home visiting director cautioned, however, that framing the data constructively during meetings is important so no one feels shamed for having a month with slow cross-referrals or enrollments.

Box VII.5. Example data elements that *P2P* monitors

- Total number of referrals to and from each partner
- Referral status
- Enrollment outcome (including whether a family was enrolled or wait-listed)
- Reason for wait-listing (by choice or because no slot was open)
- Reason why a family declined a service

Successes, Challenges, and Opportunities for Improvement

Successes

All interviewees highlighted the value of the *P2P* collective impact approach and what it took to achieve it:

- **With *P2P*, home visiting programs believe that Tehama County serves more families in home visiting than they could otherwise reach.** Although the *P2P* partners do not reach everyone in the county (especially those in the most rural places), everyone who was interviewed highlighted that engaging several organizations to spread awareness about home visiting and to link families to home visiting expands access to more families than any program could achieve alone. This mutual assistance also helps stretch each partner's funding. Further, home visitors' awareness of and connections to other providers has also made it easier to link home visiting enrollees to other services as children develop and their needs change.

"It was a real struggle when we started it because there was a lot of animosity between programs. There were a lot of things we had to work through because we were all competing for the same pool of families. It was a lot of working together and getting over the issues we had with people, with each other, and [with] other's programs."

— *P2P* leader

- ***P2P* partners achieved buy-in on a shared vision by overcoming a competitive mindset.** By all accounts, agreeing on the decision tree was hard. It took time and patience for home visiting providers to transition from the mindset of filling their own slots to investing in a "joint vision of what we would like our community to look like." The program leaders came to celebrate the programs' differences and view it as an asset that the programs offer different services to families with different needs and preferences. They also wrestled with, and came around to, offering home visiting to families while they wait for preschool, even if only for a short time. Achieving a shared

"I think the strength lies primarily in the people and the relationships, because at the end of the day, we believe the kids are all of ours. All of us live and work in Tehama County and we want the families to be served."

— *P2P* leader

vision, in turn, required substantial investment in relationships. Trust was built over time through regular *P2P* meetings, one-one-one phone calls, and sharing data. It also helped that First 5 Tehama, which does not provide services, can serve as an objective convener.

Other noted strengths of *P2P* included the following:

- **A shared referral form and closed-loop referral tracking.** Home visiting staff appreciated that the *P2P* referral form is easy for families and providers to use and is widely accessible now that it is on First 5 Tehama's website. Without it, they thought referrals between *P2P* partners would be less fluid. *P2P* leaders interviewed also highlighted that the ability to close the loop on most referrals promotes follow-through and facilitates performance monitoring and improvement.
- **Opportunities to strengthen community responsiveness.** Organic conversations at *P2P* meetings can spur the county's early care and education providers and First 5 Tehama to pursue new investments.

Challenges and opportunities for improvement

Noted challenges included the following:

- **Data system limitations.** Because it was a semi-custom build, the data system cannot easily be updated as *P2P* evolves. All interviewed *P2P* leaders agreed that although the data system does the job, it is "rudimentary" and "clunky." Further, one leader thought that if they had the funding and if partners agreed to it, having up-to-date data on partners' capacity within the data system (which they learn about at *P2P* meetings) might streamline referrals.
- **Turnover and competing demands.** *P2P* partners sometimes need to re-prioritize *P2P* meetings because they cannot always attend due to other demands. In addition, turnover at partner organizations can lead new representatives to question the need for *P2P*. To help maintain a shared vision, in 2025, the First 5 Tehama director surveyed and spoke individually with people about the usefulness of *P2P* and where they want *P2P* to go.

P2P is a living model that partners routinely aim to improve. Ongoing efforts and wish-list items included the following:

- **Ongoing training to describe home visiting to families.** *P2P* partners or other referral partners must describe home visiting while addressing families' concerns about having strangers in their homes and possible exposure to the child welfare system if their home conditions are perceived as inadequate.
- **Technical assistance to help *P2P* partners turn ideas into actions.** Three *P2P* leaders suggested such assistance when asked if any support might help them. "I think that we have all of these great ideas, so now let's move them forward," as one leader put it.
- **More funding.** First 5 Tehama's funding allocation provides for the *P2P* infrastructure, but with more funding, including for home visiting, the staff believe they could make a stronger impact.
- **Expanding to new partners,** such as by making home-based child care providers without a license aware of *P2P*.

This page has been left blank for double-sided printing.

VIII. Conclusion

Together, these six case study summaries provide detailed information about the ways centralized intake systems can be structured and implemented to support home visiting enrollment. Although each system reflects its own history, partnerships, and resources, common themes emerge about the importance of clear communication processes, strong relationships with referral partners, and data systems that support timely and accurate information sharing. By examining these examples, readers can identify strategies that resonate with their own context and consider how different approaches might strengthen outreach, screening, and referral in their communities. The range of systems profiled here underscores that there is no preferred approach for centralizing intake. Rather, states and localities can tailor their approach, building or refining systems that streamline pathways into home visiting within their unique context. Websites for each of the centralized intake systems can be found in Box VIII.1.

Box VIII.1. Learn more about the six centralized intake systems

For more information about any of the centralized intake systems featured in this report, see their websites:

- **Delaware's *Help Me Grow at 211:*** www.dethrives.com/programs/help-me-grow
- **Florida's *Connect:*** www.healthystartflorida.com
- **Indiana's *My Healthy Baby:*** www.myhealthybabyindiana.com
- **Missouri's *Coordinated Referral and Intake System:*** www.ctf4kids.org
- **New Jersey's *Connecting NJ:*** www.nj.gov/connectingnj
- **Tehama County's *Pregnancy to Preschool Partnership:*** www.first5tehama.org/pregnancy-to-preschool-partnership

This page has been left blank for double-sided printing.

Endnotes

[i] IGrow Illinois. "Developing Coordinated Intake for Your Community: What It Is and How to Start or Maintain a Strong System." 2020. https://igrowillinois.org/wp-content/uploads/2024/06/Coordinated-Intake-Toolkit-August-2020-1.pdf.

[ii] National Home Visiting Model Alliance. "Centralized Intake: Lessons Learned and Recommendations." n.d. https://www.nationalalliancehvmodels.org/copy-of-resources.

[iii] Health Resources and Services Administration. "Maternal, Infant, and Early Childhood Home Visiting Program: Report to Congress 2025." Rockville, MD: Health Resources and Services Administration, 2025. https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/home-visiting/miechv-fy-2025-report-congress.pdf

[iv] Maternal and Child Health Bureau. "Early Childhood Comprehensive Systems." 2026. https://mchb.hrsa.gov/programs-impact/early-childhood-systems/early-childhood-comprehensive-systems.

[v] Delaware Thrives. "Help Me Grow." 2025. https://dethrives.com/programs/help-me-grow.

[vi] National Institute for Children's Health Quality. "From 50th in the Nation to a National Success. Delaware Improves Early Childhood Outcomes." 2018. https://nichq.org/blog/50th-nation-national-success-delaware-improves-early-childhood-outcomes/.

[vii] United Way of Delaware. "Home Page." n.d. https://uwde.org/.

[viii] Delaware Birth to Three Early Intervention Program. "Home Page." n.d. https://www.b23de.org/.

[ix] Delaware Thrives. "Providers and Community Partners: Home Visiting." 2025. https://dethrives.com/providers-and-community-partners/home-visiting.

[x] Florida Department of Health. "Healthy Start." n.d. https://www.floridahealth.gov/programs-and-services/childrens-health/healthy-start/index.html.

[xi] Florida Department of Health. "Chapter 1: The Healthy Start System." In *Healthy Start Standards and Guidelines*, 2008. https://www.floridahealth.gov/wp-content/uploads/2025/07/chapter-1-the-healthy-start-system-2008.pdf.

[xii] The Healthy Start Coalition of Hardee, Highlands, and Polk Counties, Inc. "Florida Revised Prenatal Screen." 2024. https://healthystarthhp.org/wp-content/uploads/2024/01/english-prenatal-screen.pdf.

[xiii] Florida Department of Health. "Infant Risk Screen." n.d. https://www.floridahealth.gov/wp-content/uploads/2025/07/final-dh-3135-infant-risk-screen-01-15-English.pdf.

[xiv] Association of Maternal & Child Health Programs. "Developing, Testing & Scaling Coordinated Intake & Referral." 2018. https://amchp.org/wp-content/uploads/2021/05/CIR.pdf.

[xv] Florida Department of Health. "Healthy Start." n.d. https://www.floridahealth.gov/programs-and-services/childrens-health/healthy-start/index.html.

[xvi] Florida Department of Health. "Chapter 4: Coordinated Intake and Referral (CI&R)." In *Healthy Start Standards and Guidelines*, 2019. https://www.floridahealth.gov/wp-content/uploads/2025/07/chapter-4-coordinated-intake-and-referral-3-2019.pdf.

[xvii] Florida Association of Healthy Start Coalitions. "2025-2026 Annual Report." n.d. https://www.healthystartflorida.com/wp-content/uploads/2025/10/FAHSCAnnual-Report-2024-25.pdf.

[xviii] Florida Department of Health. "Chapter 3: Healthy Start Risk Screening." In *Healthy Start Standards and Guidelines*, 2007. https://www.floridahealth.gov/wp-content/uploads/2025/07/chapter-3-healthy-start-risk-screening-2009.pdf.

[xix] Florida Department of Children and Families. "Medicaid Redetermination: Medicaid Eligibility." n.d. https://www.myflfamilies.com/medicaid#ME.

[xx] National Center for Health Statistics. "Infant Mortality." *Stats of the States,* August 20, 2025. https://www.cdc.gov/nchs/state-stats/deaths/infant-mortality.html.

[xxi] Indiana General Assembly. *House Enrolled Act 1007*. Public Law 292, §1, IC 16-35-1-11, 2019.

[xxii] Indiana Department of Health. "My Healthy Baby 2024 Annual Report to the Legislature." November 2024.

[xxiii] Indiana Family and Social Services Administration. "Indiana 211 2024 Annual Report." April 11, 2025. https://iga.in.gov/publications/agency_report/2024-Annual-Report---Indiana-211.pdf.

[xxiv] Kania, J., and M. Kramer. "Collective Impact." *Stanford Social Innovation Review,* 2011. https://ssir.org/articles/entry/collective_impact.

[xxv] Every Child Succeeds. "About Every Child Succeeds." 2024. https://www.everychildsucceeds.org/about.

[xxvi] Children's Trust Fund. "*CRIS* Link: Missouri Home Visiting Referral System." n.d. https://ctf4kids.org/crislink/.

[xxvii] Children's Trust Fund. "*CRIS* Coordinator & Partner Toolkit." n.d. https://ctf4kids.org/mo-home-visiting-referral-system-toolkit.

[xxviii] Colvard, J., and J. Cohen. "Cross-System Collaboration to Better Support Babies in New Jersey: Providing Families With a Single Point of Entry for Accessing Services." 2019. https://www.zerotothree.org/wp-content/uploads/2022/05/Cross-System-Collaboration-to-Better-Support-Babies-in-New-Jersey_-Providing-Families-with-a-Single-Point-of-Entry-for-Accessing-Services.pdf.

[xxix] State of New Jersey. "Connecting *NJ*." (n.d.) https://nj.gov/connectingnj/.

[xxx] Hogan, V. K., E. Lee, L.A. Asare, B. Banks, L.E. Benitez Delgado, D. Bingham, and P.E. Brooks, et al. "The Nurture NJ Strategic Plan." The State of New Jersey, 2021. https://nurturenj.nj.gov/wp-content/uploads/2021/01/20210120-Nurture-NJ-Strategic-Plan.pdf

[xxxi] Family Connects NJ. "Family Connects NJ: Nurse Visits Supporting Parents & Newborns at Home." https://www.familyconnectsnj.org/.

[xxxii] Hogan, V. K., E. Lee, L.A. Asare, B. Banks, L.E. Benitez Delgado, D. Bingham, and P.E. Brooks, et al. "The Nurture NJ Strategic Plan." The State of New Jersey, 2021.

[xxxiii] Family Health Initiatives. "Guide to PRA|SPECT." 2016. https://cnjlink.org/documentation/PRA_SPECT_User_Guide_2016.pdf.

[xxxiv] Family Health Initiatives. "Guide to PRA|SPECT." 2016. https://cnjlink.org/documentation/PRA_SPECT_User_Guide_2016.pdf.

[xxxv] Family Health Initiatives. "CNJ Link Data Agreement." 2023. https://cnjlink.org/documentation/CNJLinkRequiredBAAandDSAFHI_V4-23.pdf.

[xxxvi] New Jersey Department of Labor and Workforce Development. "New Jersey Strategic Plan Preschool Development Grant Birth Through 5 (PDG B-5)." Johns Hopkins University. December 2024. https://www.nj.gov/dcf/documents/families/early/NJDCF-Strategic-Plan-PDG-5.pdf.

[xxxvii] First 5 California. "Proposition 10—The California Children and Families Act." n.d. https://www.ccfc.ca.gov/about/prop_10.html.

[xxxviii] First 5 Tehama. "Pregnancy to Preschool Partnership." n.d. https://www.first5tehama.org/pregnancy-to-preschool-partnership/. Accessed September 18, 2025.

[xxxix] Applied Survey Research. "First 5 Tehama Annual Report 2024–25." n.d. https://www.first5tehama.org/wp-content/uploads/2025/12/2024-25-F5-Tehama-Annual-Eval-Report_without-briefs.pdf.

Mathematica Inc.

Our employee-owners work nationwide and around the world.

Find us at **mathematica.org** and **edi-global.com**.



Mathematica, Progress Together, and the "spotlight M" logo are registered trademarks of Mathematica Inc.